1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	DMERC Claim Record	REC	VAR			Durable medical equipment (DME) regional carrier (DMERC) claim record for version I of the NCH. STANDARD ALIAS: DMERC_CLM_REC SYSTEM ALIAS: UTLDMERI
****	DESY Header Group	GROUP	50	1	50	
1.	DESY System User	CHAR	30	1	30	A user-defined field that holds the description of the request. For example, "Cross-referenced HICs". STANDARD ALIAS: DSY_SYSTEM_USER
2.	DESY Filler	CHAR	11	31	41	Filler STANDARD ALIAS: DSY_TBD
3.	DESY Sort Key	CHAR	9	42	50	This field contains the key to tie claims together for one beneficiary regardless of HICAN. STANDARD ALIAS: DSY_SORT_KEY
****	DMERC Claim Fixed Group	GROUP	341	51	391	Fixed portion of the durable medical equipment regional carrier (DMERC) claim record for version I of the NCH. STANDARD ALIAS: DMERC_CLM_FIX_GRP
****	Claim Record Identification Group	GROUP	8	51	58	Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing. STANDARD ALIAS: CLM_REC_IDENT_GRP
4.	Record Length Count	PACK	3	51	53	Effective with Version H, the count (in bytes) of the length of the claim record.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

5 DIGITS SIGNED

DB2 ALIAS: REC_LNGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LNGTH_CNT

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
5.	NCH Near-Line Record Version Code	CHAR	1	54	54	The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

DB2 ALIAS: NCH_REC_VRSN_CD
SAS ALIAS: REC_LVL
STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD
TITLE ALIAS: NCH_VERSION

CODES:
A = Record format as of January 1991
B = Record format as of April 1991
C = Record format as of May 1991
D = Record format as of January 1992
E = Record format as of March 1992
F = Record format as of May 1992
G = Record format as of October 1993
H = Record format as of September 1998
I = Record format as of July 2000

COMMENT:
Prior to Version H this field was named:
CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE:
NCH

6. NCH Near Line Record Identification Code	CHAR	1	55	55	A code defining the type of claim record being processed. COMMON ALIAS: RIC DB2 ALIAS: NEAR_LINE_RIC_CD SAS ALIAS: RIC_CD STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD TITLE ALIAS: RIC CODES: REFER TO: NCH_NEAR_LINE_RIC_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: RIC_CD. SOURCE: NCH
7. NCH MQA RIC Code	CHAR	1	56	56	Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through HCFA's CWFMQA system. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_MQA_RIC_CD SAS ALIAS: MQA_RIC STANDARD ALIAS: NCH_MQA_RIC_CD TITLE ALIAS: MQA_RIC

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					CODES: 1 = Inpatient 2 = SNF 3 = Hospice 4 = Outpatient

5 = Home Health Agency
6 = Physician/Supplier
7 = Durable Medical Equipment

SOURCE:
NCH QA PROCESS

8. NCH Claim Type Code	CHAR	2	57	58	The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data through- out history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97). Placeholders for Physician and Outpatient encounters (available in NMUD) have also been added.

DB2 ALIAS: NCH_CLM_TYPE_CD
SAS ALIAS: CLM_TYPE
STANDARD ALIAS: NCH_CLM_TYPE_CD
SYSTEM ALIAS: LTTYPE
TITLE ALIAS: CLAIM_TYPE

DERIVATION:
FFS CLAIM TYPE CODES DERIVED FROM:
- NCH CLM_NEAR_LINE_RIC_CD
- NCH PMT_EDIT_RIC_CD
- NCH CLM_TRANS_CD
- NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(Pre-HDC processing -- AVAILABLE IN NCH)
- CLM_MCO_PD_SW
- CLM_RLT_COND_CD
- MCO_CNTRCT_NUM
- MCO_OPTN_CD
- MCO_PRD_EFCTV_DT
- MCO_PRD_TRMNTN_DT

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
(HDC processing -- AVAILABLE IN NMUD)

FI_NUM

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (HDC processing -- AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD NOTE: From 7/1/97 to the start of HDC processing(?), abbreviated inpatient encounter claims are not available in NCH or NMUD.
					PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) CARR_NUM CLM_DEMO_ID_NUM
					OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM
					OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED FROM: (AVAILABLE IN NMUD) FI_NUM CLM_FAC_TYPE_CD CLM_SRVC_CLSFCTN_TYPE_CD CLM_FREQ_CD
					DERIVATION RULES: SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET: 1. CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U' 2. PMT_EDIT_RIC_CD EQUAL 'F' 3. CLM_TRANS_CD EQUAL '5' SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y' OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y' OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED' ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
1. FI_NUM = 80881
2. CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_CLSFCTN_TYPE_CD = '2', '3' OR '4' & CLM_FREQ_CD = 'Z', 'Y' OR 'X'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'

3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED' ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. FI_NUM = 80881 AND
2. CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
TYPE_CD = '1'; CLM_FREQ_CD = 'Z'

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CARR_NUM = 80882 AND
2. CLM_DEMO_ID_NUM = 38

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:
1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

CODES:
REFER TO: NCH_CLM_TYPE_TB
IN THE CODES APPENDIX

SOURCE:
NCH

****	Carrier/DMERC Claim Link Group	GROUP	125	59	183	Effective with Version 'I', this group was added to the carrier and DMERC records to keep fields common across all record types in the same position. Due to OP PPS, several fields on the Institutional record had to be moved to a link group so those same fields had to be moved on the carrier records eventhough OP PPS only affects institutional claims. STANDARD ALIAS: CARR_DMERC_CLM_LINK_GRP

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
****	Claim Locator Number Group	GROUP	11	59	69	This number uniquely identifies the beneficiary in the NCH Nearline. COMMON ALIAS: HIC STANDARD ALIAS: CLM_LCTR_NUM_GRP TITLE ALIAS: HICAN

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
9.	Beneficiary Claim Account Number	CHAR	9	59	67	The number identifying the primary beneficiary under the SSA or RRB programs submitted. COMMON ALIAS: CAN DA3 ALIAS: CLAIM_ACCOUNT_NUMBER DB2 ALIAS: BENE_CLM_ACNT_NUM SAS ALIAS: CAN STANDARD ALIAS: BENE_CLM_ACNT_NUM TITLE ALIAS: CAN SOURCE: SSA,RRB LIMITATIONS: RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.
10.	NCH Category Equatable Beneficiary Identification Code	CHAR	2	68	69	The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner. The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

COMMON ALIAS: NCH_BASE_CATEGORY_BIC
DB2 ALIAS: CTGRY_EQTBL_BIC
SAS ALIAS: EQ_BIC
STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD
TITLE ALIAS: EQUATED_BIC

CODES:
  REFER TO: CTGRY_EQTBL_BENE_IDENT_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CTGRY_EQTBL_BENE_IDENT_CD.

SOURCE:
BIC EQUATE MODULE

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
11.	Beneficiary Identification Code	CHAR	2	70	71	The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

COMMON ALIAS: BIC
DA3 ALIAS: BENE_IDENT_CODE
DB2 ALIAS: BENE_IDENT_CD
SAS ALIAS: BIC
STANDARD ALIAS: BENE_IDENT_CD
TITLE ALIAS: BIC

EDIT-RULES:
EDB REQUIRED FIELD

CODES:
  REFER TO: BENE_IDENT_TB
            IN THE CODES APPENDIX

SOURCE:

SSA/RRB

12. NCH State Segment Code — CHAR — 1 — 72 — 72

The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM_LCTR_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

DB2 ALIAS: NCH_STATE_SGMT_CD
SAS ALIAS: ST_SGMT
STANDARD ALIAS: NCH_STATE_SGMT_CD
TITLE ALIAS: NEAR_LINE_SEGMENT

CODES:
REFER TO: NCH_STATE_SGMT_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
BENE_STATE_SGMT_NEAR_LINE_CD.

SOURCE:
NCH

13. Beneficiary Residence SSA Standard State Code — CHAR — 2 — 73 — 74

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS: SSA_STANDARD_STATE_CODE
DB2 ALIAS: BENE_SSA_STATE_CD
SAS ALIAS: STATE_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS: BENE_STATE_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

COMMENT:
1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE:
SSA/EDB

14. Claim From Date	NUM	8	75	82	The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_FROM_DT
SAS ALIAS: FROM_DT
STANDARD ALIAS: CLM_FROM_DT
TITLE ALIAS: FROM_DATE

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

15. Claim Through Date	NUM	8	83	90	The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

8 DIGITS UNSIGNED

DB2 ALIAS: CLM_THRU_DT
SAS ALIAS: THRU_DT
STANDARD ALIAS: CLM_THRU_DT
TITLE ALIAS: THRU_DATE

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
16.	NCH Weekly Claim Processing Date	NUM	8	91	98	The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date. 8 DIGITS UNSIGNED DB2 ALIAS: NCH_WKLY_PROC_DT SAS ALIAS: WKLY_DT STANDARD ALIAS: NCH_WKLY_PROC_DT TITLE ALIAS: NCH_PROCESS_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: HCFA_CLM_PROC_DT. SOURCE: NCH
17.	CWF Claim Accretion Date	NUM	8	99	106	The date the claim record is accreted (posted/ processed) to the beneficiary master record at the CWF host site and authorization for

payment is returned to the fiscal interme-
diary or carrier.

8 DIGITS UNSIGNED

DB2 ALIAS: CWF_CLM_ACRTN_DT
SAS ALIAS: ACRTN_DT
STANDARD ALIAS: CWF_CLM_ACRTN_DT
TITLE ALIAS: ACCRETION_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
18.	CWF Claim Accretion Number	PACK	2	107	108	The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. **(Exception: If the claim record is missing the accretion date HCFA's CWFMQA system places a zero in the accretion number. 3 DIGITS SIGNED

DB2 ALIAS: CWF_CLM_ACRTN_NUM
SAS ALIAS: ACRTN_NM
STANDARD ALIAS: CWF_CLM_ACRTN_NUM
TITLE ALIAS: ACCRETION_NUMBER

SOURCE:
CWF

19.	Carrier Claim Control Number	CHAR	15	109	123	Unique control number assigned by a carrier to a non-institutional claim.

COMMON ALIAS: CCN
DB2 ALIAS: CARR_CLM_CNTL_NUM
SAS ALIAS: CARRCNTL
STANDARD ALIAS: CARR_CLM_CNTL_NUM
TITLE ALIAS: CCN

EDIT-RULES:
LEFT JUSTIFY

COMMENT:
For the physician/supplier or DMERC claim, this field allows HCFA to associate each line item with its respective claim.

SOURCE:
CWF

20. FILLER	CHAR	38	124	161	
21. NCH Daily Process Date	NUM	8	162	169	Effective with Version H, the date the claim record was processed by HCFA's CWFMQA system (used for internal editing purposes). Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/ segments together. NOTE1: With Version 'H' this field was pop- ulated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date. 8 DIGITS UNSIGNED DB2 ALIAS: NCH_DAILY_PROC_DT SAS ALIAS: DAILY_DT STANDARD ALIAS: NCH_DAILY_PROC_DT TITLE ALIAS: DAILY_PROCESS_DT EDIT-RULES: YYYYMMDD

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					SOURCE: NCH
22. NCH Segment Link Number	PACK	5	170	174	Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/ segments that come in on the same batch with the same identifying information in the link group are not mixed with each other. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). 9 DIGITS SIGNED DB2 ALIAS: NCH_SGMT_LINK_NUM SAS ALIAS: LINK_NUM STANDARD ALIAS: NCH_SGMT_LINK_NUM TITLE ALIAS: LINK_NUM SOURCE: NCH
23. Claim Total Segment Count	NUM	2	175	176	Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments. NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

2 DIGITS UNSIGNED

DB2 ALIAS: TOT_SGMT_CNT
SAS ALIAS: SGMT_CNT
STANDARD ALIAS: CLM_TOT_SGMT_CNT
TITLE ALIAS: SEGMENT_COUNT

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
24. Claim Segment Number	NUM	2	177	178	Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.

2 DIGITS UNSIGNED

DB2 ALIAS: CLM_SGMT_NUM
SAS ALIAS: SGMT_NUM
STANDARD ALIAS: CLM_SGMT_NUM
TITLE ALIAS: SEGMENT_NUMBER

SOURCE:
CWF

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
25. Claim Total Line Count	NUM	3	179	181	Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

NOTE: During the Version I conversion this field was populated with data throughout

history (back to service year 1991).
Prior to Version 'I', the maximum line count
will be no more than 58. Effective with Version
'I', the maximum line count could be 450.

3 DIGITS UNSIGNED

DB2 ALIAS: TOT_LINE_CNT
SAS ALIAS: LINECNT
STANDARD ALIAS: CLM_TOT_LINE_CNT
TITLE ALIAS: TOTAL_LINE_COUNT

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
26.	Claim Segment Line Count	NUM	2	182	183	Effective with Version I, the count used to identify the number of revenue center lines on a record/segment. NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment is 45. 2 DIGITS UNSIGNED DB2 ALIAS: SGMT_LINE_CNT SAS ALIAS: SGMTLINE STANDARD ALIAS: CLM_SGMT_LINE_CNT TITLE ALIAS: SEGMENT_LINE_COUNT

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
****	Carrier/DMERC Claim Common 2 Group	GROUP	194	184	377	Information common to both carrier and DMERC claims for version I of NCH. STANDARD ALIAS: CARR_DMERC_CLM_CMN_2_GRP

27. FILLER	CHAR	5	184	188	
28. Carrier Claim Entry Code	CHAR	1	189	189	Carrier-generated code describing whether the Part B claim is an original debit, full credit, or replacement debit. DB2 ALIAS: CARR_CLM_ENTRY_CD SAS ALIAS: ENTRY_CD STANDARD ALIAS: CARR_CLM_ENTRY_CD TITLE ALIAS: ENTRY_CD CODES: 1 = Original debit; void of original debit (If CLM_DISP_CD = 3, code 1 means voided original debit) 3 = Full credit 5 = Replacement debit 9 = Accrete bill history only (internal; effective 2/22/91) COMMENT: Prior to Version H this field was named: CWFB_CLM_ENTRY_CD. SOURCE: CWF
29. FILLER	CHAR	1	190	190	
30. Claim Disposition Code	CHAR	2	191	192	Code indicating the disposition or outcome of the processing of the claim record. DB2 ALIAS: CLM_DISP_CD SAS ALIAS: DISP_CD STANDARD ALIAS: CLM_DISP_CD TITLE ALIAS: DISPOSITION_CD CODES: REFER TO: CLM_DISP_TB IN THE CODES APPENDIX SOURCE: CWF

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
31.	NCH Edit Disposition Code	CHAR	2	193	194	Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_EDIT_DISP_CD SAS ALIAS: EDITDISP STANDARD ALIAS: NCH_EDIT_DISP_CD TITLE ALIAS: NCH_EDIT_DISP CODES: 00 = No MQA errors 10 = Possible duplicate 20 = Utilization error 30 = Consistency error 40 = Entitlement error 50 = Identification error 60 = Logical duplicate 70 = Systems duplicate SOURCE: NCH QA Process
32.	NCH Claim BIC Modify H Code	CHAR	1	195	195	Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: NCH_BIC_MDFY_CD SAS ALIAS: BIC_MDFY STANDARD ALIAS: NCH_CLM_BIC_MDFY_CD

TITLE ALIAS: BIC_MODIFY_CD

CODES:
H = BIC submitted by CWF = HA, HB or HC
blank = No HA, HB or HC BIC present

SOURCE:
NCH QA Process

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
33.	Beneficiary Residence SSA Standard County Code	CHAR	3	196	198	The SSA standard county code of a beneficiary's residence.

DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
DB2 ALIAS: BENE_SSA_CNTY_CD
SAS ALIAS: CNTY_CD
STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
TITLE ALIAS: BENE_COUNTY_CD

EDIT-RULES:
OPTIONAL: MAY BE BLANK

SOURCE:
SSA/EDB

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
34.	Carrier Claim Receipt Date	NUM	8	199	206	The date the carrier receives the non-institutional claim.

8 DIGITS UNSIGNED

DB2 ALIAS: CARR_CLM_RCPT_DT
SAS ALIAS: RCPT_DT
STANDARD ALIAS: CARR_CLM_RCPT_DT
TITLE ALIAS: RECEIPT_DT

EDIT-RULES:
YYYYMMDD

COMMENT:
Prior to Version H this field was named:
FICARR_CLM_RCPT_DT.

SOURCE:
CWF

35. Carrier Claim Scheduled Payment Date — NUM, 8, 207, 214

The scheduled date of payment to the physician or supplier, as appearing on the original non-institutional claim sent to the CWF host.
**Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

8 DIGITS UNSIGNED

DB2 ALIAS: CARR_SCHLD_PMT_DT
SAS ALIAS: SCHLD_DT
STANDARD ALIAS: CARR_CLM_SCHLD_PMT_DT
TITLE ALIAS: SCHLD_PMT_DT

EDIT-RULES:
YYYYMMDD

COMMENT:
Prior to Version H this field was named: FICARR_CLM_PMT_DT.

SOURCE:
CWF

36. CWF Forwarded Date — NUM, 8, 215, 222

Effective with Version H, the date CWF forwarded the claim record to HCFA (used for internal editing purposes).

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

8 DIGITS UNSIGNED

DB2 ALIAS: CWF_FRWRD_DT

SAS ALIAS: FRWRD_DT
STANDARD ALIAS: CWF_FRWRD_DT
TITLE ALIAS: FORWARD_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

37. Carrier Number	CHAR	5	223	227	The identification number assigned by HCFA to a carrier authorized to process claims from a physician or supplier. DB2 ALIAS: CARR_NUM SAS ALIAS: CARR_NUM STANDARD ALIAS: CARR_NUM SYSTEM ALIAS: LTCARR TITLE ALIAS: CARRIER CODES: REFER TO: CARR_NUM_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: FICARR_IDENT_NUM. SOURCE: CWF
38. FILLER	CHAR	8	228	235	
39. CWF Transmission Batch Number	CHAR	4	236	239	Effective with Version H, the number assigned to each batch of claims transactions sent from CWF(used for internal editing purposes). NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field. DB2 ALIAS: TRNSMSN_BATCH_NUM SAS ALIAS: FIBATCH

STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM
TITLE ALIAS: BATCH_NUM

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NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					SOURCE: CWF
40. Beneficiary Mailing Contact ZIP Code	CHAR	9	240	248	The ZIP code of the mailing address where the beneficiary may be contacted. DB2 ALIAS: BENE_MLG_ZIP_CD SAS ALIAS: BENE_ZIP STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD TITLE ALIAS: BENE_ZIP SOURCE: EDB
41. Beneficiary Sex Identification Code	CHAR	1	249	249	The sex of a beneficiary. COMMON ALIAS: SEX_CD DA3 ALIAS: SEX_CODE DB2 ALIAS: BENE_SEX_IDENT_CD SAS ALIAS: SEX STANDARD ALIAS: BENE_SEX_IDENT_CD SYSTEM ALIAS: LTSEX TITLE ALIAS: SEX_CD EDIT-RULES: REQUIRED FIELD CODES: 1 = Male 2 = Female 0 = Unknown SOURCE: SSA,RRB,EDB

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
42.	Beneficiary Race Code	CHAR	1	250	250	The race of a beneficiary. DA3 ALIAS: RACE_CODE DB2 ALIAS: BENE_RACE_CD SAS ALIAS: RACE STANDARD ALIAS: BENE_RACE_CD SYSTEM ALIAS: LTRACE TITLE ALIAS: RACE_CD CODES: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = North American Native SOURCE: SSA

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	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
43.	Beneficiary Birth Date	NUM	8	251	258	The beneficiary's date of birth. 8 DIGITS UNSIGNED DB2 ALIAS: BENE_BIRTH_DT SAS ALIAS: BENE_DOB STANDARD ALIAS: BENE_BIRTH_DT TITLE ALIAS: BENE_BIRTH_DATE EDIT-RULES: YYYYMMDD SOURCE: CWF
44.	CWF Beneficiary Medicare Status Code	CHAR	2	259	260	The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).

COBOL ALIAS: MSC
COMMON ALIAS: MSC
DB2 ALIAS: BENE_MDCR_STUS_CD
SAS ALIAS: MS_CD
STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
SYSTEM ALIAS: LTMSC
TITLE ALIAS: MSC

DERIVATION:
CWF derives MSC from the following:
  1. Date of Birth
  2. Claim Through Date
  3. Original/Current Reasons for entitlement
  4. ESRD Indicator
  5. Beneficiary Claim Number
Items 1,3,4,5 come from the CWF Beneficiary
Master Record; item 2 comes from the FI/Carrier
claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

CODES:
10 = Aged without ESRD
11 = Aged with ESRD
20 = Disabled without ESRD
21 = Disabled with ESRD
31 = ESRD only

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NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

COMMENT:
Prior to Version H this field was named:
BENE_MDCR_STUS_CD. The name has been changed

to distinguish this CWF-derived field from the EDB-derived MSC (BENE_MDCR_STUS_CD).

SOURCE:
CWF

45. Claim Patient 6 Position Surname	CHAR	6	261	266	The first 6 positions of the Medicare patient's surname (last name) as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field. COMMON ALIAS: PATIENT_SURNAME DB2 ALIAS: PTNT_6_PSTN_SRNM SAS ALIAS: SURNAME STANDARD ALIAS: CLM_PTNT_6_PSTN_SRNM_NAME TITLE ALIAS: PATIENT_SURNAME SOURCE: CWF
46. Claim Patient 1st Initial Given Name	CHAR	1	267	267	The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS: PATIENT_GIVEN_NAME
DB2 ALIAS: 1ST_INITL_GVN_NAME
SAS ALIAS: FRSTINIT
STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME
TITLE ALIAS: PATIENT_FIRST_INITIAL

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	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						SOURCE: CWF
47.	Claim Patient First Initial Middle Name	CHAR	1	268	268	The first initial of the Medicare patient's middle name as reported by the provider on the claim. NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types. NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field. COMMON ALIAS: PATIENT_MIDDLE_NAME DB2 ALIAS: 1ST_INITL_MDL_NAME SAS ALIAS: MDL_INIT STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME TITLE ALIAS: PATIENT_MIDDLE_INITIAL SOURCE: CWF
48.	Beneficiary CWF Location Code	CHAR	1	269	269	The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.

COMMON ALIAS: CWF_HOST
DB2 ALIAS: BENE_CWF_LOC_CD
SAS ALIAS: CWFLOCCD
STANDARD ALIAS: BENE_CWF_LOC_CD
SYSTEM ALIAS: LTCWFLOC
TITLE ALIAS: CWF_HOST

CODES:
B = Mid-Atlantic
C = Southwest
D = Northeast
E = Great Lakes
F = Great Western
G = Keystone
H = Southeast
I = South
J = Pacific

SOURCE:
CWF

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	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
49.	Claim Principal Diagnosis Code	CHAR	5	270	274	The ICD-9-CM diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided. NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer. DB2 ALIAS: PRNCPAL_DGNS_CD SAS ALIAS: PDGNS_CD STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD TITLE ALIAS: PRINCIPAL_DIAGNOSIS EDIT-RULES: ICD-9-CM

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
50.	FILLER	CHAR	1	275	275	
51.	Carrier Claim Payment Denial Code	CHAR	1	276	276	The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied. DB2 ALIAS: CARR_PMT_DNL_CD SAS ALIAS: PMTDNLCD STANDARD ALIAS: CARR_CLM_PMT_DNL_CD TITLE ALIAS: PMT_DENIAL_CD CODES: REFER TO: CARR_CLM_PMT_DNL_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_CLM_PMT_DNL_CD. SOURCE: CWF
52.	Claim Excepted/Nonexcepted Medical Treatment Code	CHAR	1	277	277	Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted. DB2 ALIAS: EXCPTD_NEXCPTD_CD SAS ALIAS: TRTMT_CD STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD TITLE ALIAS: EXCPTD_NEXCPTD_CD

CODES:

0 = No Entry
1 = Excepted
2 = Nonexcepted

SOURCE:
CWF

53. Claim Payment Amount	PACK	6	278	283	Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. **NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.) Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). It does NOT include the pass thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement. Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount. Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total payment. The

Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. NOTE: There is no CWF edit check to validate that the revenue center Medicare payment amount equals the claim level Medicare payment amount.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

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For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A

payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: CLM_PMT_AMT
SAS ALIAS: PMT_AMT
STANDARD ALIAS: CLM_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H the size of this field was S9(7)V99. Als the noninstitutional claim records carried this field as a l item. Effective with Version H, this element is a claim lev field across all claim types (and the line item field has be renamed.)

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SOURCE:
CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM_DISP_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over

					or under the actual Medicare payment amount.
54. Carrier Claim Primary Payer Paid Amount	PACK	6	284	289	Effective with Version H, the amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim. NOTE: During the Version H conversion, this field was populated with data throughout history (back to service year 1991) by summing up the line item primary payer amounts. 9.2 DIGITS SIGNED DB2 ALIAS: CARR_PRMRY_PYR_AMT SAS ALIAS: PRPAYAMT STANDARD ALIAS: CARR_CLM_PRMRY_PYR_PD_AMT TITLE ALIAS: PRIMARY_PAYER_AMOUNT EDIT-RULES: $$$$$$$$$CC SOURCE: CWF
55. FILLER	CHAR	1	290	290	
56. DMERC Claim Ordering Physician UPIN Number	CHAR	6	291	296	Effective with Version G, the unique physician identification number (UPIN) of the physician ordering the Part B services/DMEPOS item. DB2 ALIAS: ORDRG_PHYSN_UPIN SAS ALIAS: ORD_UPIN STANDARD ALIAS: DMERC_CLM_ORDRG_PHYSN_UPIN_NUM TITLE ALIAS: ORDRG_UPIN COMMENT: Prior to Version H this field was named: CWFB_CLM_ORDRG_PHYSN_UPIN_NUM. SOURCE: CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
57.	DMERC Claim Ordering Physician NPI Number	CHAR	10	297	306	A placeholder field (effective with Version H) for storing the NPI assigned to the physician ordering the Part B services/DMEPOS item. COMMON ALIAS: ORDERING_PHYSICIAN_NPI DB2 ALIAS: ORDRG_PHYSN_NPI SAS ALIAS: ORD_NPI STANDARD ALIAS: DMERC_CLM_ORDRG_PHYSN_NPI_NUM TITLE ALIAS: ORDRG_NPI SOURCE: CWF
58.	Carrier Claim Provider Assignment Indicator Switch	CHAR	1	307	307	A switch indicating whether or not the provider accepts assignment for the noninstitutional claim. DB2 ALIAS: PRVDR_ASGNMT_SW SAS ALIAS: ASGMNTCD STANDARD ALIAS: CARR_CLM_PRVDR_ASGNMT_IND_SW TITLE ALIAS: ASSIGNMENT_SW CODES: A = Assigned claim N = Non-assigned claim COMMENT: Prior to Version H this field was named: CWFB_CLM_PRVDR_ASGNMT_IND_SW. SOURCE: CWF
59.	NCH Claim Provider Payment Amount	PACK	6	308	313	Effective with Version H, the total payments made to the provider for this claim (sum of line item provider payment amounts.) NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain

zeroes in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: NCH_PRVDR_PMT_AMT
SAS ALIAS: PROV_PMT
STANDARD ALIAS: NCH_CLM_PRVDR_PMT_AMT
TITLE ALIAS: PRVDR_PMT

SOURCE:
NCH QA Process

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
60.	NCH Claim Beneficiary Payment Amount	PACK	6	314	319	Effective with Version H, the total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)

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NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: NCH_BENE_PMT_AMT
SAS ALIAS: BENE_PMT
STANDARD ALIAS: NCH_CLM_BENE_PMT_AMT
TITLE ALIAS: BENE_PMT

SOURCE:
NCH QA Process

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
61.	Carrier Claim Beneficiary Paid Amount	PACK	6	320	325	Effective with Version H, the amount paid by the beneficiary for the non-institutional Part B services.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: CARR_BENE_PD_AMT
SAS ALIAS: BENEPAID
STANDARD ALIAS: CARR_CLM_BENE_PD_AMT
TITLE ALIAS: BENE_PD_AMT

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
62.	NCH Carrier Claim Submitted Charge Amount	PACK	6	326	331	Effective with Version H, the total submitted charges on the claim (the sum of line item submitted charges). NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). 9.2 DIGITS SIGNED DB2 ALIAS: CARR_SBMT_CHRG_AMT SAS ALIAS: SBMTCHRG STANDARD ALIAS: NCH_CARR_SBMT_CHRG_AMT TITLE ALIAS: SBMT_CHRG EDIT-RULES: $$$$$$$$$CC SOURCE: NCH QA Process

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
63.	NCH Carrier Claim Allowed Charge Amount	PACK	6	332	337	Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges). NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

9.2 DIGITS SIGNED

DB2 ALIAS: CARR_ALOW_CHRG_AMT
SAS ALIAS: ALOWCHRG
STANDARD ALIAS: NCH_CARR_ALOW_CHRG_AMT
TITLE ALIAS: ALOW_CHRG

EDIT-RULES:
$$$$$$$CC

SOURCE:
NCH QA Process

64. Carrier Claim Cash Deductible Applied Amount	PACK	6	338	343	Effective with Version H, the amount of the cash deductible as submitted on the claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 9.2 DIGITS SIGNED DB2 ALIAS: CASH_DDCTBL_AMT SAS ALIAS: DEDAPPLY STANDARD ALIAS: CARR_CLM_CASH_DDCTBL_APPLY_AMT TITLE ALIAS: CASH_DDCTBL SOURCE: CWF
65. Carrier Claim HCPCS Year Code	NUM	1	344	344	Effective with Version H, the terminal digit of HCPCS version used to code the claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 1 DIGIT UNSIGNED DB2 ALIAS: CARR_HCPCS_YR_CD SAS ALIAS: HCPCS_YR

STANDARD ALIAS: CARR_CLM_HCPCS_YR_CD
TITLE ALIAS: HCPCS_YR

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	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						SOURCE: CWF
66.	Carrier Claim MCO Override Indicator Code	CHAR	1	345	345	Effective with Version H, the code used to indicate whether or not an MCO investigation applies to the claim (used for internal CWFMQA editing purposes). NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MCO_OVRRD_IND_CD SAS ALIAS: MCOOVRRD STANDARD ALIAS: CARR_CLM_MCO_OVRRD_IND_CD TITLE ALIAS: MCO_OVERRIDE CODES: 0 = No Investigation 1 = MCO Investigation does not apply to this claim. SOURCE: CWF
67.	Carrier Claim Hospice Override Indicator Code	CHAR	1	346	346	Effective with Version H, the code used to indicate whether or not an Hospice investigation applies to the claim (used for internal CWFMQA editing purposes). NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS: HOSPC_OVRRD_IND_CD
SAS ALIAS: HOSPOVRD
STANDARD ALIAS: CARR_CLM_HOSPC_OVRRD_IND_CD
TITLE ALIAS: HOSPC_OVERRIDE

CODES:
0 = No Investigation
1 = Hospice investigation shown not applicable
   to this claim.

SOURCE:
CWF

68. FILLER CHAR 31 347 377

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	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
69.	DMERC NCH Edit Code Count	NUM	2	378	379	The count of the number of edit codes annotated to the DMERC claim during HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: DMERC_EDIT_CD_CNT SAS ALIAS: DEDCNT STANDARD ALIAS: DMERC_NCH_EDIT_CD_CNT COMMENT: Prior to Version H this field was named: CLM_EDIT_CD_CNT. SOURCE: NCH
70.	DMERC NCH Patch Code Count	NUM	2	380	381	Effective with Version H, the count of the number of HCFA patch codes annotated to the DMERC claim during the Nearline maintenance

process. The purpose of this count is to indicate how many NCH patch trailers are present.
NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

2 DIGITS UNSIGNED

DB2 ALIAS: DMERC_PATCH_CD_CNT
SAS ALIAS: DPATCNT
STANDARD ALIAS: DMERC_NCH_PATCH_CD_I_CNT

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
71.	DMERC MCO Period Count	NUM	1	382	382	Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on a DMERC claim. The purpose of this count is to indicate how many MCO period trailers are present. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field. 1 DIGIT UNSIGNED DB2 ALIAS: DMERC_MCO_PRD_CNT SAS ALIAS: DMCOCNT STANDARD ALIAS: DMERC_MCO_PRD_CNT

EDIT-RULES:
RANGE: 0 TO 2

SOURCE:
NCH

72.	DMERC Claim Health PlanID Count	NUM	1	383	383	A placeholder field (effective with Version H) for storing the count of the number of Health PlanIDs reported on the DMERC claim. The purpose of this count is to indicate how many Health PlanId trailers are present. NOTE: Prior to Version 'I' this field was named: DMERC_CLM_PAYERID_CNT. 1 DIGIT UNSIGNED DB2 ALIAS: DMERC_PLANID_CNT SAS ALIAS: DPLNCNT STANDARD ALIAS: DMERC_CLM_HLTH_PLANID_CNT EDIT-RULES: RANGE: 0 TO 3 SOURCE: NCH
73.	DMERC Claim Demonstration ID Count	NUM	1	384	384	Effective with Version H, the count of the number of claim demonstration IDs reported on an DMERC claim. The purpose of this count is to indicate how many claim demonstration trailers are present. NOTE: During the Version H conversion this field was populated with data where a demo was identifiable. 1 DIGIT UNSIGNED DB2 ALIAS: DMERC_DEMO_ID_CNT SAS ALIAS: DDEMCNT STANDARD ALIAS: DMERC_CLM_DEMO_ID_CNT EDIT-RULES: RANGE: 0 TO 5 SOURCE: NCH
74.	DMERC Claim Diagnosis Code Count	NUM	1	385	385	The count of the number of diagnosis codes (both principal and other) reported on a DMERC claim.

The purpose of this count is to indicate how
many claim diagnosis trailers are present.

1 DIGIT UNSIGNED

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NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					DB2 ALIAS: DMERC_DGNS_CD_CNT SAS ALIAS: DDGNCNT STANDARD ALIAS: DMERC_CLM_DGNS_CD_CNT EDIT-RULES: RANGE: 0 TO 4 COMMENT: Prior to Version H this field was named: CLM_DGNS_CD_CNT. SOURCE: NCH
75. DMERC Claim Line Count	NUM	2	386	387	The count of the number of line items reported on the DMERC claim. The purpose of this count is to indicate how many line item trailers are present. 2 DIGITS UNSIGNED DB2 ALIAS: DMERC_CLM_LINE_CNT SAS ALIAS: DLINECNT STANDARD ALIAS: DMERC_CLM_LINE_CNT EDIT-RULES: RANGE: 1 TO 13 COMMENT: Prior to Version H this field was named: CWFB_CLM_NUM_LINE_ITM_CNT. SOURCE: CWFB CLAIMS

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
76.	FILLER	CHAR	4	388	391	
****	DMERC Claim Variable Group	GROUP	VAR			Variable portion of the durable medical equipment (DME) regional carrier (DMERC) claim record for version H of the NCH. STANDARD ALIAS: DMERC_CLM_VAR_GRP
****	NCH Edit Group	GROUP	5			The number of claim edit trailers is determined by the claim edit code count. OCCURS: UP TO 13 TIMES DEPENDING ON DMERC_NCH_EDIT_CD_CNT STANDARD ALIAS: NCH_EDIT_GRP
77.	NCH Edit Trailer Indicator Code	CHAR	1			Effective with Version H, the code indicating the presence of an NCH edit trailer.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: EDIT_TRLR_IND_CD SAS ALIAS: EDITIND STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD CODES: E = Edit code trailer present SOURCE: NCH QA Process
78.	NCH Edit Code	CHAR	4			The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.

COMMON ALIAS: QA_ERROR_CODE
DB2 ALIAS: NCH_EDIT_CD
SAS ALIAS: EDIT_CD
STANDARD ALIAS: NCH_EDIT_CD
TITLE ALIAS: QA_ERROR_CD

CODES:
REFER TO: NCH_EDIT_TB
IN THE CODES APPENDIX

SOURCE:
NCH QA EDIT PROCESS

**** NCH Patch Group GROUP 11

OCCURS: UP TO 30 TIMES
DEPENDING ON DMERC_NCH_PATCH_CD_I_CNT

STANDARD ALIAS: NCH_PATCH_GRP

79. NCH Patch Trailer Indicator Code CHAR 1

Effective with Version H, the code indicating the presence of an NCH patch trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS: PATCH_TRLR_IND_CD
SAS ALIAS: PATCHIND
STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD

CODES:
P = Patch code trailer present

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SOURCE:
NCH

80. NCH Patch Code	CHAR	2	Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing. NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD. DB2 ALIAS: NCH_PATCH_CD SAS ALIAS: PATCHCD STANDARD ALIAS: NCH_PATCH_CD TITLE ALIAS: NCH_PATCH CODES: REFER TO: NCH_PATCH_TB IN THE CODES APPENDIX SOURCE: NCH
81. NCH Patch Applied Date	NUM	8	Effective with Version H, the date the NCH patch was applied to the claim. 8 DIGITS UNSIGNED DB2 ALIAS: NCH_PATCH_APPLY_DT SAS ALIAS: PATCHDT STANDARD ALIAS: NCH_PATCH_APPLY_DT TITLE ALIAS: NCH_PATCH_DT EDIT-RULES: YYYYMMDD SOURCE: NCH
**** MCO Period Group	GROUP	37	The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.

OCCURS: UP TO 2 TIMES
DEPENDING ON DMERC_MCO_PRD_CNT

STANDARD ALIAS: MCO_PRD_GRP

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
82.	NCH MCO Trailer Indicator Code	CHAR	1			Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. COBOL ALIAS: MCO_IND DB2 ALIAS: MCO_TRLR_IND_CD SAS ALIAS: MCOIND STANDARD ALIAS: NCH_MCO_TRLR_IND_CD TITLE ALIAS: MCO_INDICATOR CODES: M = MCO trailer present SOURCE: NCH QA Process
83.	MCO Contract Number	CHAR	5			Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO). NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field. DB2 ALIAS: MCO_CNTRCT_NUM SAS ALIAS: MCONUM

STANDARD ALIAS: MCO_CNTRCT_NUM
TITLE ALIAS: MCO_NUM

SOURCE:
CWF

84. MCO Option Code — CHAR — 1

Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS: MCO_OPTN_CD
SAS ALIAS: MCOOPTN
STANDARD ALIAS: MCO_OPTN_CD
TITLE ALIAS: MCO_OPTION_CD

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

CODES:
*****For lock-in beneficiaries****
A = HCFA to process all provider bills
B = MCO to process only in-plan
C = MCO to process all Part A and Part B bills

***** For non-lock-in beneficiaries*****
1 = HCFA to process all provider bills
2 = MCO to process only in-plan Part A and
Part B bills

SOURCE:
CWF

85. MCO Period Effective Date — NUM — 8

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

8 DIGITS UNSIGNED

DB2 ALIAS: MCO_PRD_EFCTV_DT
SAS ALIAS: MCOEFFDT
STANDARD ALIAS: MCO_PRD_EFCTV_DT
TITLE ALIAS: MCO_PERIOD_EFF_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

86. MCO Period Termination Date	NUM	8			Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

8 DIGITS UNSIGNED

DB2 ALIAS: MCO_PRD_TRMNTN_DT
SAS ALIAS: MCOTRMDT
STANDARD ALIAS: MCO_PRD_TRMNTN_DT
TITLE ALIAS: MCO_PERIOD_TERM_DT

EDIT-RULES:
YYYYMMDD

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

SOURCE:
CWF

87.	MCO Health PLANID Number	CHAR	14	A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named: MCO_PAYERID_NUM. DB2 ALIAS: MCO_PLANID_NUM SAS ALIAS: MCOPLNID STANDARD ALIAS: MCO_HLTH_PLANID_NUM TITLE ALIAS: MCO_PLANID COMMENT: Prior to Version I this field was named: MCO_PAYERID_NUM. SOURCE: CWF
****	Claim Health PlanID Group	GROUP	16	The number of Health PlanID data trailers is determined by the claim Health PlanID trailer count. Prior to Version 'I' this field was named: CLM_PAYERID_GRP. OCCURS: UP TO 3 TIMES DEPENDING ON DMERC_CLM_HLTH_PLANID_CNT STANDARD ALIAS: CLM_HLTH_PLANID_GRP
88.	NCH Health PlanID Trailer Indicator Code	CHAR	1	A placeholder field (effective with Version H) for storing the code that indicates the presence of a Health PlanID trailer. NOTE: Prior to Version 'I' this field was named: NCH_PAYERID_TRLR_IND_CD. DB2 ALIAS: PLANID_TRLR_CD SAS ALIAS: PLANIDIN STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD CODES: I = Health PlanID trailer present COMMENT: Prior to Version I this field was named:

NCH_PAYERID_TRLR_IND_CD.

SOURCE:
NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
89.	Claim Health PlanID Code	CHAR	1			A placeholder field (effective with Version H) for storing the code identifying the type of Health PlanID. Prior to Version 'I' this field was named: CLM_PAYERID-CD

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

DB2 ALIAS: CLM_PLANID_CD
SAS ALIAS: PLANIDCD
STANDARD ALIAS: CLM_HLTH_PLANID_CD
TITLE ALIAS: PLANID_TYPE

CODES:
1 = Medicare Secondary Payer
2 = Medicaid
3 = Medigap
4 = Supplemental Insurer
5 = Managed Care Organization

COMMENT:
Prior to Version I this field was named:
CLM_PAYERID_CD.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
90.	Claim Health PlanID Number	CHAR	14			A placeholder field (effective with Version H) for storing the Health PlanID number. Prior to Version 'I' this field was named: CLM_PAYERID_NUM.

DB2 ALIAS: CLM_PLANID_NUM
SAS ALIAS: PLANID
STANDARD ALIAS: CLM_HLTH_PLANID_NUM
TITLE ALIAS: PLANID

COMMENT:
Prior to Version I this field was named:
CLM_PAYERID_NUM.

SOURCE:
CWF

**** Claim Demonstration Identification Group — GROUP — 18

The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.

OCCURS: UP TO 5 TIMES
DEPENDING ON DMERC_CLM_DEMO_ID_CNT

STANDARD ALIAS: CLM_DEMO_ID_GRP

91. NCH Demonstration Trailer Indicator Code — CHAR — 1

Effective with Version H, the code indicating the presence of a demo trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

COBOL ALIAS: DEMO_IND
DB2 ALIAS: DEMO_TRLR_IND_CD
SAS ALIAS: DEMOIND
STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD
TITLE ALIAS: DEMO_INDICATOR

CODES:
D = Demo trailer present

SOURCE:
NCH

92. Claim Demonstration Identification Number — CHAR — 2

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing

Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97,

Demo ID '02' was derived in NCH based on HCFA/ CHPP-supplied listing of provider # and start/ stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96) -- since 7/97, CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03' was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.

05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods

at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presences of the MCO Plan Contract #.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from parti-cipating hospitals. Demo ID '06' will end once Demo ID '07' is implemented.

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer

that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Participating Centers of Excellence (PCOE) Demo -- testing a negotiated all-inclusive pricing arrangement (bundled rates) for high-cost acute care cardiovascular and orthopedic procedures performed in 60-100 premier facilities in the Chicago and San Francisco Regions or by current CABG providers. The inpatient claims will contain a DRG '104','105','106', '107','112','124','125','209',or '471'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '07' to claim.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #.

30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

31 = VA Pricing Special Processing (SPN) -- not really

a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improve outcomes of care and reduce Medicare expenditures under Part A and Part B. There will be at least 9 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '37' to claim.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. **NOT IN NCH -- AVAILABLE IN NMUD.**

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

DB2 ALIAS: CLM_DEMO_ID_NUM
SAS ALIAS: DEMONUM
STANDARD ALIAS: CLM_DEMO_ID_NUM
TITLE ALIAS: DEMO_ID

SOURCE:
CWF

93.	Claim Demonstration Information Text	CHAR	15	Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2 ALIAS: CLM_DEMO_INFO_TXT
SAS ALIAS: DEMOTXT
STANDARD ALIAS: CLM_DEMO_INFO_TXT
TITLE ALIAS: DEMO_INFO

DERIVATION:
DERIVATION RULES:
Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain

W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
						Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'. Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'. SOURCE: CWF
****	Carrier Claim Diagnosis Group	GROUP	7			OCCURS: UP TO 4 TIMES DEPENDING ON DMERC_CLM_DGNS_CD_CNT

STANDARD ALIAS: CARR_CLM_DGNS_GRP

94. NCH Diagnosis Trailer Indicator Code — CHAR, 1

Effective with Version H, the code indicating the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS: DGNS_TRLR_IND_CD
SAS ALIAS: DGNSIND
STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD

CODES:
Y = Diagnosis code trailer present

SOURCE:
NCH

95. Claim Diagnosis Code — CHAR, 5

The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:
Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.

DB2 ALIAS: CLM_DGNS_CD
SAS ALIAS: DGNS_CD
STANDARD ALIAS: CLM_DGNS_CD
TITLE ALIAS: DIAGNOSIS

EDIT-RULES:
ICD-9-CM

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

COMMENT:
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD.

96.	FILLER	CHAR	1	
****	DMERC Line Item Group	GROUP	260	The DMERC line item trailer group may occur multiple times in one DMERC claim. OCCURS: UP TO 13 TIMES DEPENDING ON DMERC_CLM_LINE_CNT STANDARD ALIAS: DMERC_LINE_GRP
97.	NCH Line Item Trailer Indicator Code	CHAR	1	Effective with Version H, the code indicating the presence of a line item trailer on the non-institutional claim. NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991). DB2 ALIAS: LINE_TRLR_IND_CD SAS ALIAS: LINEIND STANDARD ALIAS: NCH_LINE_TRLR_IND_CD CODES: L = Line Item trailer present Blank = No trailer present SOURCE: NCH
98.	DMERC Line Supplier Provider Number	CHAR	10	Effective with Version G, billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim. DB2 ALIAS: SUPLR_PRVDR_NUM SAS ALIAS: SUPLRNUM STANDARD ALIAS: DMERC_LINE_SUPLR_PRVDR_NUM TITLE ALIAS: SUPLR_NUM

COMMENT:
Prior to Version H this field was named:
CWFB_SUPLR_PRVDR_NUM.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
99.	DMERC Line Item Supplier NPI Number	CHAR	10			A placeholder field (effective with Version H) for storing the NPI assigned to the supplier of the Part B service/DMEPOS line item.

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

COMMON ALIAS: SUPPLIER_NPI
DB2 ALIAS: SUPLR_NPI_NUM
SAS ALIAS: SUP_NPI
STANDARD ALIAS: DMERC_LINE_SUPLR_NPI_NUM
TITLE ALIAS: SUPLR_NPI

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
100.	DMERC Line Pricing State Code	CHAR	2			Effective with Version G, the SSA standard state code (converted from the state postal abbreviation) representing the pricing location of the service reported on the DMERC line item. This is usually the beneficiary state of residence. Note: the BENE_RSDNC_SSA_STD_STATE_CD reported in the fixed portion of the DMERC claim record may differ from this field. This can happen when the beneficiary is in another state when the service is rendered (other than the primary residence state), or the beneficiary has moved to another state and the CWF master record has not yet been changed. DB2 ALIAS: DMERC_PRCNG_STATE SAS ALIAS: PRCNG_ST

STANDARD ALIAS: DMERC_LINE_PRCNG_STATE_CD
TITLE ALIAS: DMERC_PRCNG_STATE_CD

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_DME_PRCNG_STATE_CD.

SOURCE:
CWF/NCH

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
101.	DMERC Line Provider State Code	CHAR	2			Effective with Version G, the SSA standard state code (converted from the state postal abbreviation) representing the supplier's location, as reported on the DMERC line item. NOTE: Although created for Version 'G', this field was blank until 1/95 when the supplier state code was added to the DME claim record as a required field. DB2 ALIAS: DMERC_PRVDR_STATE SAS ALIAS: PRVSTATE STANDARD ALIAS: DMERC_LINE_PRVDR_STATE_CD TITLE ALIAS: DMERC_PRVDR_STATE_CD

CODES:
REFER TO: GEO_SSA_STATE_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_DME_PRVDR_STATE_CD.

SOURCE:
CWF/NCH

102.	DMERC Line Supplier Type Code	CHAR	1	Code identifying the type of supplier furnishing the line item service on the DMERC claim. DB2 ALIAS: SUPLR_TYPE_CD SAS ALIAS: SUP_TYPE STANDARD ALIAS: DMERC_LINE_SUPLR_TYPE_CD TITLE ALIAS: SUPLR_TYPE CODES: REFER TO: DMERC_LINE_SUPLR_TYPE_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field on the DMERC claim was named: CWFB_PRVDR_TYPE_CD. SOURCE: CWF
103.	Line Provider Tax Number	CHAR	10	Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the noninstitutional claim. DB2 ALIAS: LINE_PRVDR_TAX_NUM SAS ALIAS: TAX_NUM STANDARD ALIAS: LINE_PRVDR_TAX_NUM TITLE ALIAS: PRVDR_TAX_NUM COMMENT: Prior to Version H this field was named: CWFB_PRVDR_TAX_NUM. SOURCE: CWF
104.	Line HCFA Provider Specialty Code	CHAR	2	HCFA specialty code used for pricing the line item service on the noninstitutional claim.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						DB2 ALIAS: HCFA_SPCLTY_CD SAS ALIAS: HCFASPCL STANDARD ALIAS: LINE_HCFA_PRVDR_SPCLTY_CD TITLE ALIAS: HCFA_PRVDR_SPCLTY CODES: REFER TO: HCFA_PRVDR_SPCLTY_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_HCFA_PRVDR_SPCLTY_CD. SOURCE: CWF
105.	Line Provider Participating Indicator Code	CHAR	1			Code indicating whether or not a provider is participating or accepting assignment for this line item service on the noninstitutional claim. DB2 ALIAS: PRVDR_PRTCPTG_CD SAS ALIAS: PRTCPTG STANDARD ALIAS: LINE_PRVDR_PRTCPTG_IND_CD TITLE ALIAS: PRVDR_PRTCPTG_IND CODES: REFER TO: LINE_PRVDR_PRTCPTG_IND_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_PRVDR_PRTCPTG_IND_CD. SOURCE: CWF
106.	Line Service Count	PACK	2			The count of the total number of services processed for the line item on the non-institutional claim.

3 DIGITS SIGNED

DB2 ALIAS: SRVC_CNT
SAS ALIAS: SRVC_CNT
STANDARD ALIAS: LINE_SRVC_CNT

COMMENT:
Prior to Version H this field was named:
CWFB_SRVC_CNT.
SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
107.	Line HCFA Type Service Code	CHAR	1			Code indicating the type of service, as defined in the HCFA Medicare Carrier Manual, for this line item on the non-institutional claim.

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DB2 ALIAS: HCFA_TYPE_SRVC_CD
SAS ALIAS: TYPSRVCB
STANDARD ALIAS: LINE_HCFA_TYPE_SRVC_CD
SYSTEM ALIAS: LTTOS
TITLE ALIAS: HCFA_TYPE_SRVC

EDIT-RULES:
The only type of service codes applicable to DMERC
claims are: 1, 9, A, E, G, H, J, K, L, M, P,
R, and S.

CODES:
REFER TO: HCFA_TYPE_SRVC_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_HCFA_TYPE_SRVC_CD.

SOURCE:
CWF

108. Line Place Of Service Code CHAR 2 The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the noninstitutional claim.

COMMON ALIAS: POS
DB2 ALIAS: LINE_PLC_SRVC_CD
SAS ALIAS: PLCSRVC
STANDARD ALIAS: LINE_PLC_SRVC_CD
TITLE ALIAS: PLC_SRVC

CODES:
REFER TO: LINE_PLC_SRVC_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_PLC_SRVC_CD.

SOURCE:
CWF

109. Line First Expense Date NUM 8 Beginning date (1st expense) for this line item service on the noninstitutional claim.

8 DIGITS UNSIGNED

DB2 ALIAS: LINE_1ST_EXPNS_DT
SAS ALIAS: EXPNSDT1
STANDARD ALIAS: LINE_1ST_EXPNS_DT
TITLE ALIAS: 1ST_EXPNS_DT

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

EDIT-RULES:
YYYYMMDD

COMMENT:
Prior to Version H this field was named:
CWFB_1ST_EXPNS_DT.

SOURCE:
CWF

110. Line Last Expense Date	NUM	8	The ending date (last expense) for the line item service on the noninstitutional claim. 8 DIGITS UNSIGNED COBOL ALIAS: LST_EXP_DT DB2 ALIAS: LINE_LAST_EXPNS_DT SAS ALIAS: EXPNSDT2 STANDARD ALIAS: LINE_LAST_EXPNS_DT TITLE ALIAS: LAST_EXPNS_DT EDIT-RULES: YYYYMMDD COMMENT: Prior to Version H this field was named: CWFB_LAST_EXPNS_DT. SOURCE: CWF
111. Line HCPCS Code	CHAR	5	The Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below: DB2 ALIAS: LINE_HCPCS_CD SAS ALIAS: HCPCS_CD STANDARD ALIAS: LINE_HCPCS_CD TITLE ALIAS: HCPCS_CD COMMENT: Prior to Version H this line item field was named: HCPCS_CD. With Version H, a prefix

was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE).

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NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
					Level I Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services. **** Note: **** CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright. Level II Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes. Level III Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not

represented in the level I or level II codes.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
112.	Line HCPCS Initial Modifier Code	CHAR	2			A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the noninstitutional claim. DB2 ALIAS: HCPCS_1ST_MDFR_CD SAS ALIAS: MDFR_CD1 STANDARD ALIAS: LINE_HCPCS_INITL_MDFR_CD TITLE ALIAS: INITIAL_MODIFIER EDIT-RULES: CARRIER INFORMATION FILE

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	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						COMMENT: Prior to Version H this field was named: HCPCS_INITL_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE). SOURCE: CWF
113.	Line HCPCS Second Modifier Code	CHAR	2			A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim. DB2 ALIAS: HCPCS_2ND_MDFR_CD SAS ALIAS: MDFR_CD2 STANDARD ALIAS: LINE_HCPCS_2ND_MDFR_CD TITLE ALIAS: SECOND_MODIFIER EDIT-RULES:

CARRIER INFORMATION FILE

COMMENT:
Prior to Version H this field was named:
HCPCS_2ND_MDFR_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
noninstitutional: LINE).

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
114.	DMERC Line HCPCS Third Modifier Code	CHAR	2			Effective with Version G, a third modifier to the HCPCS procedure code used to process the DMERC line item. DB2 ALIAS: HCPCS_3RD_MDFR_CD SAS ALIAS: MDFR_CD3 STANDARD ALIAS: DMERC_LINE_HCPCS_3RD_MDFR_CD TITLE ALIAS: HCPCS_3RD_MDFR COMMENT: Prior to Version H this field was named: HCPCS_3RD_MDFR_CD. SOURCE: CWF
115.	DMERC Line HCPCS Fourth Modifier Code	CHAR	2			Effective with Version G, a fourth modifier to the HCPCS procedure code used to process the DMERC line item. DB2 ALIAS: HCPCS_4TH_MDFR_CD SAS ALIAS: MDFR_CD4 STANDARD ALIAS: DMERC_LINE_HCPCS_4TH_MDFR_CD TITLE ALIAS: HCPCS_4TH_MDFR COMMENT:

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Prior to Version H this field was named:
HCPCS_4TH_MDFR_CD.

SOURCE:
CWF

116. Line NCH BETOS Code	CHAR	3	Effective with Version H, the Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. This field is included as a line item on the noninstitutional claim. NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991). DB2 ALIAS: LINE_NCH_BETOS_CD SAS ALIAS: BETOS STANDARD ALIAS: LINE_NCH_BETOS_CD SYSTEM ALIAS: LTBETOS TITLE ALIAS: BETOS DERIVATION: DERIVED FROM: LINE_HCPCS_CD LINE_HCPCS_INITL_MDFR_CD LINE_HCPCS_2ND_MDFR_CD HCPCS MASTER FILE DERIVATION RULES: Match the HCPCS on the claim to the HCPCS on the HCPCS Master File to obtain the BETOS code. CODES: REFER TO: BETOS_TB IN THE CODES APPENDIX SOURCE: NCH
117. Line IDE Number	CHAR	7	Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer

has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96

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						(which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. NOTE: Prior to Version H a dummy line item was created in the last occurrence of line item group to store IDE. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There will be only one distinct IDE number reported on the non-institutional claim. During the Version H conversion, the IDE was moved from the dummy line item to its own dedicated field for each line item (i.e., the IDE was repeated on all line items on the claim.) DB2 ALIAS: LINE_IDE_NUM SAS ALIAS: LINE_IDE STANDARD ALIAS: LINE_IDE_NUM TITLE ALIAS: IDE_NUMBER SOURCE: CWF
118.	DMERC Line Not Otherwise Classified HCPCS Code Text	CHAR	14			Effective with Version G, the text describing the not otherwise classified HCPCS code relating to this DMERC line item. DB2 ALIAS: NOC_HCPCS_CD_TXT SAS ALIAS: NOC_TXT STANDARD ALIAS: DMERC_LINE_NOC_HCPCS_CD_TXT TITLE ALIAS: NOC_HCPCS_TXT COMMENT: Prior to Version H this field was named:

CWFB_DME_ITM_NOC_HCPCS_CD_TXT.

SOURCE:
CWF

119. Line National Drug Code — CHAR — 11

Effective 1/1/94 on the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs. Effective with Version H, this line item field was added as a placeholder on the carrier claim.

DB2 ALIAS: LINE_NATL_DRUG_CD
SAS ALIAS: NDC_CD
STANDARD ALIAS: LINE_NATL_DRUG_CD
TITLE ALIAS: NDC_CD

SOURCE:
CWF

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NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

120. Line NCH Payment Amount — PACK — 6

Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim.

9.2 DIGITS SIGNED

COMMON ALIAS: REIMBURSEMENT
DB2 ALIAS: LINE_NCH_PMT_AMT
SAS ALIAS: LINEPMT
STANDARD ALIAS: LINE_NCH_PMT_AMT
TITLE ALIAS: REIMBURSEMENT

EDIT-RULES:
$$$$$$$$CC

COMMENT:
Prior to Version H this line item field was named: CLM_PMT_AMT and the size of this field was S9(7)V99.

SOURCE:
NCH

121. Line Beneficiary Payment Amount — PACK — 6 — Effective with Version H, the payment (reimbursement) made to the beneficiary related to the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_BENE_PMT_AMT
SAS ALIAS: LBENPMT
STANDARD ALIAS: LINE_BENE_PMT_AMT
TITLE ALIAS: BENE_PMT_AMT

SOURCE:
CWF

122. Line Provider Payment Amount — PACK — 6 — Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED

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DB2 ALIAS: LINE_PRVDR_PMT_AMT
SAS ALIAS: LPRVPMT
STANDARD ALIAS: LINE_PRVDR_PMT_AMT
TITLE ALIAS: PRVDR_PMT_AMT

SOURCE:
CWF

123. Line Beneficiary Part B Deductible Amount — PACK — 6

The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line item service on the noninstitutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_DDCTBL_AMT
SAS ALIAS: LDEDAMT
STANDARD ALIAS: LINE_BENE_PTB_DDCTBL_AMT
TITLE ALIAS: PTB_DED_AMT

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H this field was named: BENE_PTB_DDCTBL_LBLTY_AMT and the size of the field was S9(3)V99.

SOURCE:
CWF

124. Line Beneficiary Primary Payer Code — CHAR — 1

The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the noninstitutional claim.

DB2 ALIAS: LINE_PRMRY_PYR_CD
SAS ALIAS: LPRPAYCD
STANDARD ALIAS: LINE_BENE_PRMRY_PYR_CD
TITLE ALIAS: PRIMARY_PAYER_CD

CODES:
  REFER TO: BENE_PRMRY_PYR_TB
            IN THE CODES APPENDIX

COMMENT:

Prior to Version H this field was named:
BENE_PRMRY_PYR_CD.

SOURCE:
CWF,VA,DOL,SSA

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	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
125.	Line Beneficiary Primary Payer Paid Amount	PACK	6			The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for to the line ITEM SERVICE ON THE NONINSTITUTIONAL. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_PRMRY_PYR_PD SAS ALIAS: LPRPDAMT STANDARD ALIAS: LINE_BENE_PRMRY_PYR_PD_AMT TITLE ALIAS: PRMRY_PYR_PD EDIT-RULES: $$$$$$$$$CC COMMENT: Prior to Version H this field was named: BENE_PRMRY_PYR_PMT_AMT and the field size was S9(5)V99. SOURCE: CWF
126.	Line Coinsurance Amount	PACK	6			Effective with Version H, the beneficiary coinsurance liability amount for this line item service on the noninstitutional claim. NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_COINSRNC_AMT
SAS ALIAS: COINAMT
STANDARD ALIAS: LINE_COINSRNC_AMT
TITLE ALIAS: COINSRNC_AMT

SOURCE:
CWF

127. Line Interest Amount — PACK — 6 — Amount of interest to be paid for this line item service on the noninstitutional claim. **NOTE: This is not included in the line item NCH payment (reimbursement) amount.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_INTRST_AMT
SAS ALIAS: LINT_AMT
STANDARD ALIAS: LINE_INTRST_AMT
TITLE ALIAS: INTRST_AMT

NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H this field was named:
CWFB_INTRST_AMT and the field size was
S9(5)V99.

SOURCE:
CWF

128. Line Primary Payer Allowed Charge Amount — PACK — 6 — Effective with Version H, the primary payer allowed charge amount for the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date

10/3/97 this field was populated with data.
Claims processed prior to 10/3/97 will contain
zeroes in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: PRMRY_PYR_ALOW_AMT
SAS ALIAS: PRPYALOW
STANDARD ALIAS: LINE_PRMRY_PYR_ALOW_CHRG_AMT
TITLE ALIAS: PRMRY_PYR_ALOW_CHRG

SOURCE:
CWF

129. Line 10% Penalty Reduction Amount — PACK — 6

Effective with Version H, the 10% payment reduction amount (applicable to a late filing claim) for the line item service. on the noninstitutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: TENPCT_PNLTY_AMT
SAS ALIAS: PNLTYAMT
STANDARD ALIAS: LINE_10PCT_PNLTY_RDCTN_AMT
TITLE ALIAS: TENPCT_PNLTY

SOURCE:
CWF

130. Line Submitted Charge Amount — PACK — 6

The amount of submitted charges for the line item service on the noninstitutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_SBMT_CHRG_AMT
SAS ALIAS: LSBMTCHG
STANDARD ALIAS: LINE_SBMT_CHRG_AMT
TITLE ALIAS: SBMT_CHRG

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EDIT-RULES:
$$$$$$$$CC

COMMENT:
Prior to Version H this field was named:
CWFB_SBMT_CHRG_AMT and the field size was
S9(5)V99.

SOURCE:
CWF

131. Line Allowed Charge Amount	PACK	6	The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. **NOTE: The allowed charge is determined by the lower of three charges: prevailing, customary or actual. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_ALOW_CHRG_AMT SAS ALIAS: LALOWCHG STANDARD ALIAS: LINE_ALOW_CHRG_AMT TITLE ALIAS: ALOW_CHRG EDIT-RULES: $$$$$$$$CC COMMENT: Prior to Version H this field was named: CWFB_ALOW_CHRG_AMT and the field size was S9(5)V99. SOURCE: CWF
132. DMERC Line Screen Savings Amount	PACK	6	Effective with Version G, the amount of savings attributable to the coverage screen for this DMERC line item. 9.2 DIGITS SIGNED DB2 ALIAS: LINE_SCRN_SVGS_AMT SAS ALIAS: SCRNSVGS

STANDARD ALIAS: DMERC_LINE_SCRN_SVGS_AMT
TITLE ALIAS: SCRN_SVGS

COMMENT:
Prior to Version H this field was named:
CWFB_DME_SCRN_SVGS_AMT and the field size was
S9(5)V99.

SOURCE:
CWF

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	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
133.	Line DME Purchase Price Amount	PACK	6			Effective 5/92, the amount representing the lower of fee schedule for purchase of new or used DME, or actual charge. In case of rental DME, this amount represents the purchase cap; rental payments can only be made until the cap is met. This line item field is applicable to non-institutional claims involving DME, prosthetic, orthotic and supply items, immunosuppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS. 9.2 DIGITS SIGNED DB2 ALIAS: DME_PURC_PRICE_AMT SAS ALIAS: DME_PURC STANDARD ALIAS: LINE_DME_PURC_PRICE_AMT TITLE ALIAS: DME_PURC_PRICE EDIT-RULES: $$$$$$$$CC COMMENT: Prior to Version H this field was named: CWFB_DME_PURC_PRICE_AMT and the field size was S9(5)V99. SOURCE: CWF

134.	Line Processing Indicator Code	CHAR	1	The code indicating the reason a line item on the noninstitutional claim was allowed or denied. DB2 ALIAS: LINE_PRCSG_IND_CD SAS ALIAS: PRCNGIND STANDARD ALIAS: LINE_PRCSG_IND_CD TITLE ALIAS: PRCSG_IND CODES: REFER TO: LINE_PRCSG_IND_TB IN THE CODES APPENDIX COMMENT: Prior to Version H this field was named: CWFB_PRCSG_IND_CD. SOURCE: CWF
135.	Line Payment 80%/100% Code	CHAR	1	The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.

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NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
					COMMON ALIAS: REIMBURSEMENT_IND DB2 ALIAS: LINE_PMT_80_100_CD SAS ALIAS: PMTINDSW STANDARD ALIAS: LINE_PMT_80_100_CD TITLE ALIAS: REINBURSEMENT_IND CODES: 0 = 80% 1 = 100% 3 = 100% Limitation of liability only

COMMENT:
Prior to Version H this field was named:
CWFB_PMT_80_100_CD.

SOURCE:
CWF

136. Line Service Deductible Indicator Switch — CHAR — 1

Switch indicating whether or not the line item service on the noninstitutional claim is subject to a deductible.

DB2 ALIAS: SRVC_DDCTBL_SW
SAS ALIAS: DED_SW
STANDARD ALIAS: LINE_SRVC_DDCTBL_IND_SW
TITLE ALIAS: SRVC_DED_IND

CODES:
0 = Service subject to deductible
1 = Service not subject to deductible

COMMENT:
Prior to Version H this field was named:
CWFB_SRVC_DDCTBL_IND_SW.

SOURCE:
CWF

137. Line Payment Indicator Code — CHAR — 1

Code that indicates the payment screen used to determine the allowed charge for the line item service on the noninstitutional claim.

DB2 ALIAS: LINE_PMT_IND_CD
SAS ALIAS: PMTINDCD
STANDARD ALIAS: LINE_PMT_IND_CD
TITLE ALIAS: PMT_IND

CODES:
  REFER TO: LINE_PMT_IND_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_PMT_IND_CD.

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						SOURCE: CWF
138.	DMERC Line Miles/Time/Units/Services Count	PACK	4			Effective with Version G, the count of the total units associated with the DMERC line item service needing unit reporting, including number of services, volume of oxygen and drug dose. 7 DIGITS SIGNED DB2 ALIAS: DMERC_MTUS_CNT SAS ALIAS: DME_UNIT STANDARD ALIAS: DMERC_LINE_MTUS_CNT TITLE ALIAS: MTUS_CNT COMMENT: Prior to Version H this field was named: CWFB_DME_MTUS_CNT. SOURCE: CWF
139.	DMERC Line Miles/Time/Units/Services Indicator Code	CHAR	1			Effective with Version G, the code indicating the type of units reported for the DMERC line item. DB2 ALIAS: DMERC_MTUS_IND_CD SAS ALIAS: UNIT_IND STANDARD ALIAS: DMERC_LINE_MTUS_IND_CD TITLE ALIAS: MTUS_IND CODES: 0 = Values reported as zero 3 = Number of services 4 = Oxygen volume units 6 = Drug dosage COMMENT: Prior to Version H this field was named: CWFB_DME_MTUS_IND_CD.

SOURCE:
CWF

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
140.	Line Diagnosis Code	CHAR	5			The ICD-9-CM code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim. DB2 ALIAS: LINE_DGNS_CD SAS ALIAS: LINEDGNS STANDARD ALIAS: LINE_DGNS_CD TITLE ALIAS: DGNS_CD EDIT-RULES: ICD-9-CM

COMMENT:
Prior to Version H this field was named:
CWFB_LINE_DGNS_CD.

SOURCE:
CWF

141.	FILLER	CHAR	1			
142.	Line Additional Claim Documentation Indicator Code	CHAR	1			Effective 5/92, the code indicating additional claim documentation was submitted for this line item service on the noninstitutional claim. COMMON ALIAS: DOCUMENT_IND DB2 ALIAS: ADDTNL_DCMTN_CD SAS ALIAS: DCMTN_CD STANDARD ALIAS: LINE_ADDTNL_CLM_DCMTN_IND_CD TITLE ALIAS: ADDTNL_DCMTN_IND EDIT-RULES: In any case where more than one value is applicable, highest number is shown.

CODES:
REFER TO: LINE_ADDTNL_CLM_DCMTN_IND_TB
IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_ADDTNL_CLM_DCMTN_IND_CD.

SOURCE:
CWF

143. DMERC Line Screen Suspension Indicator Code — CHAR, 4

Effective with Version G, the code identifying the medical review (MR) screen that caused DMERC line item to suspend.

DB2 ALIAS: SCRN_SUSPNSN_CD
SAS ALIAS: SUSP_IND
STANDARD ALIAS: DMERC_LINE_SCRN_SUSPNSN_IND_CD
TITLE ALIAS: SCRN_SUSPNSN_IND

CODES:
MUXX = Mandated unbundling screens
UXXX = Local unbundling screens
CXXX = Statutorily noncovered screens
M1XX = Mandate CAT I screens
1XXX = Local CAT I screens
M2XX = Mandate CAT II screens
2XXX = Local CAT II screens
M3XX = Mandate CAT III screens
3XXX = Local CAT III screens

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SOURCE:
CWF

144. DMERC Line Screen Result Indicator Code — CHAR, 1

Effective with Version G, code indicating the outcome of the medical review (MR) unit's evaluation of the DMERC line item.

DB2 ALIAS: SCRN_RSLT_IND_CD
SAS ALIAS: RSLT_IND
STANDARD ALIAS: DMERC_LINE_SCRN_RSLT_IND_CD
TITLE ALIAS: SCRN_RSLT_IND

CODES:
  REFER TO: DMERC_LINE_SCRN_RSLT_IND_TB
            IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_DME_SCRN_RSLT_IND_CD.

SOURCE:
CWF

145.	DMERC Line Waiver Of Provider Liability Switch	CHAR	1	Effective with Version G, the switch indicating the beneficiary was notified that the item, reported as a DMERC line item, may not be considered medically necessary and has agreed in writing to pay for the item.

DB2 ALIAS: WVR_PRVDR_LBLTY_SW
SAS ALIAS: WAIVERSW
STANDARD ALIAS: DMERC_LINE_WVR_PRVDR_LBLTY_SW
TITLE ALIAS: WAIVER_LBLTY_SW

CODES:
Y = Yes
N = No

COMMENT:
Prior to Version H this field was named:
CWFB_DME_WVR_PRVDR_LBLTY_SW.

SOURCE:
CWF

146.	DMERC Line Decision Indicator Switch	CHAR	1	Effective with Version G, the switch identifying whether the DMERC claim represents an original decision or a reversal of an earlier decision on the original claim.

DB2 ALIAS: DMERC_DCSN_IND_SW

SAS ALIAS: DCSN_IND
STANDARD ALIAS: DMERC_LINE_DCSN_IND_SW
TITLE ALIAS: DCSN_IND

1 DMERC Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

	NAME	TYPE	LENGTH	POSITIONS BEG	POSITIONS END	CONTENTS
						CODES: O = Original MR determination R = MR determination after reversal of original decision COMMENT: Prior to Version H this field was named: CWFB_DME_DCSN_IND_SW. SOURCE: CWF
147.	FILLER	CHAR	50			
148.	End of Record Code	CHAR	3			Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim. DB2 ALIAS: END_REC_CD SAS ALIAS: EOR STANDARD ALIAS: END_REC_CD TITLE ALIAS: END_OF_REC CODES: EOR = End of Record/Segment EOC= End of Claim COMMENT: Prior to Version I this field was named: END_REC_CNSTNT. SOURCE: NCH

1 BENE_IDENT_TB Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant
B = Aged wife, age 62 or over (1st claimant)
B1 = Aged husband, age 62 or over (1st claimant)
B2 = Young wife, with a child in her care (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9,CA-CZ = Child (includes minor, student or disabled child)
D = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of age 60) (1st claimant)
D5 = Widower (remarried after attainment of age 60) (1st claimant)

D6 = Surviving divorced wife, age 60 or over
(1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DC = Surviving divorced husband (1st claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
DH = Aged widower (3rd claimant)
DJ = Aged widower (4th claimant)
DK = Aged widower (5th claimant)
DL = Remarried widow (4th claimant)
DM = Surviving divorced husband (2nd
claimant)
DN = Remarried widow (5th claimant)

1 BENE_IDENT_TB Beneficiary Identification Code (BIC) Table

DP = Remarried widower (2nd claimant)
DQ = Remarried widower (3rd claimant)
DR = Remarried widower (4th claimant)
DS = Surviving divorced husband (3rd
claimant)
DT = Remarried widower (5th claimant)
DV = Surviving divorced wife (3rd claimant)
DW = Surviving divorced wife (4th claimant)
DX = Surviving divorced husband (4th
claimant)
DY = Surviving divorced wife (5th claimant)
DZ = Surviving divorced husband (5th
claimant)
E = Mother (widow) (1st claimant)
E1 = Surviving divorced mother (1st
claimant)
E2 = Mother (widow) (2nd claimant)
E3 = Surviving divorced mother (2nd
claimant)
E4 = Father (widower) (1st claimant)
E5 = Surviving divorced father (widower)
(1st claimant)
E6 = Father (widower) (2nd claimant)
E7 = Mother (widow) (3rd claimant)
E8 = Mother (widow) (4th claimant)

E9 = Surviving divorced father (widower)
(2nd claimant)
EA = Mother (widow) (5th claimant)
EB = Surviving divorced mother (3rd
claimant)
EC = Surviving divorced mother (4th
claimant)
ED = Surviving divorced mother (5th
claimant
EF = Father (widower) (3rd claimant)
EG = Father (widower) (4th claimant)
EH = Father (widower) (5th claimant)
EJ = Surviving divorced father (3rd
claimant)
EK = Surviving divorced father (4th
claimant)
EM = Surviving divorced father (5th
claimant)
F1 = Father
F2 = Mother
F3 = Stepfather
F4 = Stepmother
F5 = Adopting father
F6 = Adopting mother
F7 = Second alleged father
F8 = Second alleged mother
J1 = Primary prouty entitled to HIB
(less than 3 Q.C.) (general fund)
J2 = Primary prouty entitled to HIB
(over 2 Q.C.) (RSI trust fund)
J3 = Primary prouty not entitled to HIB
(less than 3 Q.C.) (general fund)
J4 = Primary prouty not entitled to HIB

1 BENE_IDENT_TB Beneficiary Identification Code (BIC) Table

(over 2 Q.C.) (RSI trust fund)
K1 = Prouty wife entitled to HIB (less than
3 Q.C.) (general fund) (1st claimant)
K2 = Prouty wife entitled to HIB (over 2
Q.C.) (RSI trust fund) (1st claimant)
K3 = Prouty wife not entitled to HIB (less
than 3 Q.C.) (general fund) (1st
claimant)

K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)
K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)
K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)
K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)
KC = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)
KD = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (4th claimant)
KE = Prouty wife entitled to HIB (over 2 Q.C (4th claimant)
KF = Prouty wife not entitled to HIB (less than 3 Q.C.)(4th claimant)
KG = Prouty wife not entitled to HIB (over 2 Q.C.)(4th claimant)
KH = Prouty wife entitled to HIB (less than 3 Q.C.)(5th claimant)
KJ = Prouty wife entitled to HIB (over 2 Q.C.) (5th claimant)
KL = Prouty wife not entitled to HIB (less than 3 Q.C.)(5th claimant)
KM = Prouty wife not entitled to HIB (over 2 Q.C.) (5th claimant)
M = Uninsured-not qualified for deemed HIB
M1 = Uninsured-qualified but refused HIB
T = Uninsured-entitled to HIB under deemed or renal provisions
TA = MQGE (primary claimant)

TB = MQGE aged spouse (first claimant)
TC = MQGE disabled adult child (first claimant)
TD = MQGE aged widow(er) (first claimant)
TE = MQGE young widow(er) (first claimant)
TF = MQGE parent (male)
TG = MQGE aged spouse (second claimant)

1 BENE_IDENT_TB Beneficiary Identification Code (BIC) Table

TH = MQGE aged spouse (third claimant)
TJ = MQGE aged spouse (fourth claimant)
TK = MQGE aged spouse (fifth claimant)
TL = MQGE aged widow(er) (second claimant)
TM = MQGE aged widow(er) (third claimant)
TN = MQGE aged widow(er) (fourth claimant)
TP = MQGE aged widow(er) (fifth claimant)
TQ = MQGE parent (female)
TR = MQGE young widow(er) (second claimant)
TS = MQGE young widow(er) (third claimant)
TT = MQGE young widow(er) (fourth claimant)
TU = MQGE young widow(er) (fifth claimant)
TV = MQGE disabled widow(er) fifth claimant
TW = MQGE disabled widow(er) first claimant
TX = MQGE disabled widow(er) second claimant
TY = MQGE disabled widow(er) third claimant
TZ = MQGE disabled widow(er) fourth claimant
T2-T9 = Disabled child (second to ninth claimant)
W = Disabled widow, age 50 or over (1st claimant)
W1 = Disabled widower, age 50 or over (1st claimant)
W2 = Disabled widow (2nd claimant)
W3 = Disabled widower (2nd claimant)
W4 = Disabled widow (3rd claimant)
W5 = Disabled widower (3rd claimant)
W6 = Disabled surviving divorced wife (1st claimant)
W7 = Disabled surviving divorced wife (2nd claimant)
W8 = Disabled surviving divorced wife (3rd claimant)
W9 = Disabled widow (4th claimant)
WB = Disabled widower (4th claimant)

WC = Disabled surviving divorced wife (4th
claimant)
WF = Disabled widow (5th claimant)
WG = Disabled widower (5th claimant)
WJ = Disabled surviving divorced wife (5th
claimant)
WR = Disabled surviving divorced husband
(1st claimant)
WT = Disabled surviving divorced husband
(2nd claimant)

Railroad Retirement Board:

NOTE:
Employee: a Medicare beneficiary who is
still working or a worker who
died before retirement
Annuitant: a person who retired under the
railroad retirement act on or
after 03/01/37
Pensioner: a person who retired prior to
03/01/37 and was included in the
railroad retirement act

1 BENE_IDENT_TB Beneficiary Identification Code (BIC) Table
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10 = Retirement - employee or annuitant
80 = RR pensioner (age or disability)
14 = Spouse of RR employee or annuitant
(husband or wife)
84 = Spouse of RR pensioner
43 = Child of RR employee
13 = Child of RR annuitant
17 = Disabled adult child of RR annuitant
46 = Widow/widower of RR employee
16 = Widow/widower of RR annuitant
86 = Widow/widower of RR pensioner
43 = Widow of employee with a child in her care
13 = Widow of annuitant with a child in her care
83 = Widow of pensioner with a child in her care
45 = Parent of employee
15 = Parent of annuitant
85 = Parent of pensioner

11 = Survivor joint annuitant
(reduced benefits taken to insure benefits
for surviving spouse)

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

A = Working aged bene/spouse with employer
group health plan (EGHP)
B = End stage renal disease (ESRD) beneficiary
in the 18 month coordination period with
an employer group health plan
C = Conditional payment by Medicare; future
reimbursement expected
D = Automobile no-fault (eff. 4/97; Prior
to 3/94, also included any liability
insurance)
E = Workers' compensation
F = Public Health Service or other federal
agency (other than Dept. of Veterans
Affairs)
G = Working disabled bene (under age 65
with LGHP)
H = Black Lung
I = Dept. of Veterans Affairs
J = Any liability insurance
(eff. 3/94 - 3/97)
L = Any liability insurance (eff. 4/97)
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

M = Override code: EGHP services involved
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

N = Override code: non-EGHP services involved
(eff. 12/90 for carrier claims and 10/93
for FI claims; obsoleted for all claim
types 7/1/96)

BLANK = Medicare is primary payer (not sure

of effective date: in use 1/91, if not earlier)

T = MSP cost avoided - IEQ contractor (eff. 7/96 carrier claims only)
U = MSP cost avoided - HMO rate cell adjustment contractor (eff. 7/96 carrier claims only)
V = MSP cost avoided - litigation settlement contractor (eff. 7/96 carrier claims only)

X = MSP cost avoided override code (eff. 12/90 for carrier claims and 10/93 for FI claims; obsoleted for all claim types 7/1/96)

Prior to 12/90

Y = Other secondary payer investigation shows Medicare as primary payer

1 BENE_PRMRY_PYR_TB — Beneficiary Primary Payer Table

Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK indicate Medicare is primary payer. (values Z and Y were used prior to 12/90. BLANK was suppose to be effective after 12/90, but may have been used prior to that date.)

1 BETOS_TB — BETOS Table

M1A = Office visits - new
M1B = Office visits - established
M2A = Hospital visit - initial
M2B = Hospital visit - subsequent
M2C = Hospital visit - critical care
M3 = Emergency room visit
M4A = Home visit

M4B = Nursing home visit
M5A = Specialist - pathology
M5B = Specialist - psychiatry
M5C = Specialist - opthamology
M5D = Specialist - other
M6 = Consultations
P0 = Anesthesia
P1A = Major procedure - breast
P1B = Major procedure - colectomy
P1C = Major procedure - cholecystectomy
P1D = Major procedure - turp
P1E = Major procedure - hysterctomy
P1F = Major procedure - explor/decompr/excisdisc
P1G = Major procedure - Other
P2A = Major procedure, cardiovascular-CABG
P2B = Major procedure, cardiovascular-Aneurysm repair
P2C = Major Procedure, cardiovascular-Thromboendarterectomy
P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
P2E = Major procedure, cardiovascular-Pacemaker insertion
P2F = Major procedure, cardiovascular-Other
P3A = Major procedure, orthopedic - Hip fracture repair
P3B = Major procedure, orthopedic - Hip replacement
P3C = Major procedure, orthopedic - Knee replacement
P3D = Major procedure, orthopedic - other
P4A = Eye procedure - corneal transplant
P4B = Eye procedure - cataract removal/lens insertion
P4C = Eye procedure - retinal detachment
P4D = Eye procedure - treatment
P4E = Eye procedure - other
P5A = Ambulatory procedures - skin
P5B = Ambulatory procedures - musculoskeletal
P5C = Ambulatory procedures - inguinal hernia repair
P5D = Ambulatory procedures - lithotripsy
P5E = Ambulatory procedures - other
P6A = Minor procedures - skin
P6B = Minor procedures - musculoskeletal
P6C = Minor procedures - other (Medicare fee schedule)
P6D = Minor procedures - other (non-Medicare fee schedule)
P7A = Oncology - radiation therapy
P7B = Oncology - other
P8A = Endoscopy - arthroscopy
P8B = Endoscopy - upper gastrointestinal
P8C = Endoscopy - sigmoidoscopy
P8D = Endoscopy - colonoscopy

P8E = Endoscopy - cystoscopy
P8F = Endoscopy - bronchoscopy
P8G = Endoscopy - laparoscopic cholecystectomy
P8H = Endoscopy - laryngoscopy
P8I = Endoscopy - other
P9A = Dialysis services

1 BETOS_TB BETOS Table
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I1A = Standard imaging - chest
I1B = Standard imaging - musculoskeletal
I1C = Standard imaging - breast
I1D = Standard imaging - contrast gastrointestinal
I1E = Standard imaging - nuclear medicine
I1F = Standard imaging - other
I2A = Advanced imaging - CAT: head
I2B = Advanced imaging - CAT: other
I2C = Advanced imaging - MRI: brain
I2D = Advanced imaging - MRI: other
I3A = Echography - eye
I3B = Echography - abdomen/pelvis
I3C = Echography - heart
I3D = Echography - carotid arteries
I3E = Echography - prostate, transrectal
I3F = Echography - other
I4A = Imaging/procedure - heart including cardiac catheter
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies

D1D = Wheelchairs
D1E = Other DME
D1F = Orthotic devices
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Vision, hearing and speech services
O1G = Influenza immunization
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

1 CARR_CLM_PMT_DNL_TB — Carrier Claim Payment Denial Table

0 = Denied
1 = Physician/supplier
2 = Beneficiary
3 = Both physician/supplier and beneficiary
4 = Hospital (hospital based physicians)
5 = Both hospital and beneficiary
6 = Group practice prepayment plan
7 = Other entries (e.g. Employer, union)
8 = Federally funded
9 = PA service
A = Beneficiary under limitation of
    liability
B = Physician/supplier under limitation of
    liability
D = Denied due to demonstration involvement
    (eff. 5/97)
E = MSP cost avoided IRS/SSA/HCFA Data
    Match (eff. 7/3/00)
F = MSP cost avoided HMO Rate Cell
    (eff. 7/3/00)
G = MSP cost avoided Litigation Settlement
    (eff. 7/3/00)
H = MSP cost avoided Employer Voluntary
    Reporting (eff. 7/3/00)
J = MSP cost avoided Insurer Voluntary

Reporting (eff. 7/3/00)
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)
T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)
V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)

1 CARR_LINE_PRVDR_TYPE_TB — Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

0 = Clinics, groups, associations, partnerships, or other entities
1 = Physicians or suppliers reporting as solo practitioners
2 = Suppliers (other than sole proprietorship)
3 = Institutional provider
4 = Independent laboratories
5 = Clinics (multiple specialties)
6 = Groups (single specialty)
7 = Other entities

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
2 = Physicians or suppliers billing as solo practitioners for whom the carrier's

own physician ID code is shown.
3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

1CARR_LINE_RDCD_PHYSN_ASTNT_TB Carrier Line Part B Reduced Physician Assistant Table

BLANK = Adjustment situation (where CLM_DISP_CD equal 3)
0 = N/A
1 = 65%
A) Physician assistants assisting in surgery
B) Nurse midwives
2 = 75%
A) Physician assistants performing services in a hospital (other than assisting surgery)
B) Nurse practitioners and clinical nurse specialists performing services in rural areas
C) Clinical social worker services
3 = 85%
A) Physician assistant services for other than assisting surgery
B) Nurse practitioners services

1 CARR_NUM_TB

Carrier Number Table

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisianna - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983;
term. 1997)
00580 = District of Columbia - Pennsylvania BS
(eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995)
(term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.)
(eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
(eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
(eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)

00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona - North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;
term. 1999)
00865 = Pennsylvania BS (eff. 1983)
00870 = Rhode Island BS (eff. 1983)
00880 = South Carolina BS (eff. 1983)
00882 = RRB - South Carolina PGBA (eff. 2000)

1 CARR_NUM_TB Carrier Number Table

00885 = DMERC C - Palmetto (eff. 1993)
00900 = Texas BS (eff. 1983)
00901 = Maryland - Texas BS (eff. 1995)
00902 = Delaware - Texas BS (eff. 1998)
00903 = District of Columbia - Texas BS (eff. 1998)
00904 = Virginia - Texas BS (eff. 2000)
00910 = Utah BS (eff. 1983)
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
00974 = Triple-S, Inc. - Virgin Islands
01020 = Alaska - AETNA (eff. 1983; term. 1997)
01030 = Arizona - AETNA (eff. 1983; term. 1997)
01040 = Georgia - AETNA (eff. 1988; term. 1997)
01120 = Hawaii - AETNA (eff. 1983; term. 1997)
01290 = Nevada - AETNA (eff. 1983; term. 1997)
01360 = New Mexico - AETNA (eff. 1986; term. 1997)
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
01380 = Oregon - AETNA (eff. 1983; term. 1997
01390 = Washington - AETNA (eff. 1994; term. 1997)
02050 = California - TOLIC (eff. 1983)

(term. 2000)
03070 = Connecticut General Life Insurance Co.
(eff. 1983; term. 1985)
05130 = Idaho - Connecticut General (eff. 1983)
05320 = New Mexico - Equitable Insurance
(eff. 1983; term. 1985)
05440 = Tennessee - Connecticut General (eff. 1983)
05530 = Wyoming - Equitable Insurance (eff. 1983)
(term. 1989)
05535 = North Carolina - Connecticut General
(eff. 1988)
05655 = DMERC-D - Connecticut General (eff. 1993)
10071 = Railroad Board Travelers (eff. 1983)
(term. 2000)
10230 = Connecticut - Metra Health (eff. 1986)
(term. 2000)
10240 = Minnesota - Metra Health (eff. 1983)
(term. 2000)
10250 = Mississippi - Metra Health (eff. 1983)
(term. 2000)
10490 = Virginia - Metra Health (eff. 1983)
(term. 2000)
10555 = Travelers Insurance Co. (eff. 1993)
(term. 2000)
11260 = Missouri - General American Life
(eff. 1983; term. 1998)
14330 = New York - GHI (eff. 1983)
16360 = Ohio - Nationwide Insurance Co.
16510 = West Virginia - Nationwide Insurance Co.
21200 = Maine - BS of Massachusetts
31140 = California - National Heritage Ins.
31142 = Maine - National Heritage Ins.
31143 = Massachusetts - National Heritage Ins.
31144 = New Hampshire - National Heritage Ins.
31145 = Vermont - National Heritage Ins.

1 CARR_NUM_TB Carrier Number Table

31146 = So. California - NHIC (eff. 2000)

1 CLM_DISP_TB Claim Disposition Table
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01 = Debit accepted
02 = Debit accepted (automatic adjustment)
applicable through 4/4/93
03 = Cancel accepted
61 = *Conversion code: debit accepted
62 = *Conversion code: debit accepted
(automatic adjustment)
63 = *Conversion code: cancel accepted

*Used only during conversion period:
1/1/91 - 2/21/91

1 CTGRY_EQTBL_BENE_IDENT_TB — Category Equatable Beneficiary Identification Code (BIC) Table

NCH BIC	SSA Categories
A	A;J1;J2;J3;J4;M;M1;T;TA
B	B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;TB(F);TD(F);TE(F);TW(F)
B1	B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)TD(M);TE(M);TW(M)
B3	B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2W7;TG(F);TL(F);TR(F);TX(F)
B4	B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)TL(M);TR(M);TX(M)
B8	B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4W8;TH(F);TM(F);TS(F);TY(F)
BA	BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9WC;TJ(F);TN(F);TT(F);TZ(F)
BD	BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WFWJ;TK(F);TP(F);TU(F);TV(F)
BG	BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)TY(M)
BH	BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)TZ(M)
BJ	BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)TV(M)
C1	C1;TC
C2	C2;T2
C3	C3;T3
C4	C4;T4

C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
equatable to F3)
CA-CZ = Equatable only to itself. (e.g., CA is
only equatable to CA)

RRB Categories

10 = 10
11 = 11
13 = 13;17
14 = 14;16
15 = 15
43 = 43
45 = 45
46 = 46
80 = 80
83 = 83
84 = 84;86
85 = 85

1 DMERC_LINE_SCRN_RSLT_IND_TB — DMERC Line Screen Result Indicator Table

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A = Denied for lack of medical necessity;
highest level of review was automated
level I review
B = Reduced (partially denied) for lack
of medical necessity; highest level
of review was automated level I review
C = Denied as statutorily noncovered;
highest level of review was automated
level I review
D = Reserved for future use
E = Paid after automated level I review
F = Denied for lack of medical necessity;

highest level of review was manual
level I review
G = Reduced (partially denied) for lack
of medical necessity; highest level
of review was manual level I review
H = Denied as statutorily noncovered;
highest level of review was manual
level I review
I = Denied for coding/unbundling reasons;
highest level of review was manual
level I review
J = Paid after manual level I review
K = Denied for lack of medical necessity;
highest level of review was manual
level II review
L = Reduced (partially denied) for lack
of medical necessity; highest level
of review was manual level II review
M = Denied as statutorily noncovered;
highest level of review was manual
level II review
N = Denied for coding/unbundling reasons;
highest level of review was manual
level II review
O = Paid after manual level II review
P = Denied for lack of medical necessity;
highest level of review was manual
level III review
Q = Reduced (partially denied) for lack
of medical necessity; highest level
of review was manual level III review
R = Denied as statutorily noncovered;
highest level of review was manual
level III review
S = Denied for coding/unbundling reasons;
highest level of review was manual
level III review
T = Paid after manual level III review

1 DMERC_LINE_SUPLR_TYPE_TB DMERC Line Supplier Type Table
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0 = Clinics, groups, associations,

partnerships, or other entities
for whom the carrier's own ID number
has been assigned.
1 = Physicians or suppliers billing as
solo practitioners for whom SSN's are
shown in the physician ID code field.
2 = Physicians or suppliers billing as
solo practitioners for whom the carrier's
own physician ID code is shown.
3 = Suppliers (other than sole proprietorship)
for whom EI numbers are used in coding the
ID field.
4 = Suppliers (other than sole proprietorship)
for whom the carrier's own code has been
shown.
5 = Institutional providers and
independent laboratories for whom EI
numbers are used in coding the ID field.
6 = Institutional providers and
independent laboratories for whom the
carrier's own ID number is shown.
7 = Clinics, groups, associations, or
partnerships for whom EI numbers
are used in coding the ID field.
8 = Other entities for whom EI numbers
are used in coding the ID field or
proprietorship for whom EI numbers are
used in coding the ID field.

1 GEO_SSA_STATE_TB State Table

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado
07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia

12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennessee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia

56 = Canada & Islands
57 = Central America and West Indies

1 GEO_SSA_STATE_TB — State Table

58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = U.S. Possessions
64 = American Samoa
65 = Guam
66 = Saipan
97 = Northern Marianas
98 = Guam
99 = With 000 county code is American Samoa; otherwise unknown

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

Prior to 5/92

01 = General practice
02 = General surgery
03 = Allergy (revised 10/91 to mean allergy/immunology)
04 = Otology, laryngology, rhinology revised 10/91 to mean otolaryngology)
05 = Anesthesiology
06 = Cardiovascular disease (revised 10/91 to mean cardiology)
07 = Dermatology
08 = Family practice
09 = Gynecology--osteopaths only (deleted 10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only) (revised 10/91 to mean osteopathic manipulative therapy)
13 = Neurology

14 = Neurological surgery (revised 10/91 to
mean neurosurgery)
15 = Obstetrics--osteopaths only (deleted
10/91; changed to '16')
16 = OB-gynecology
17 = Ophthalmology, otology, laryngology
rhinology--osteopaths only (deleted
10/91; changed to '18' if physicians
practice is more than 50% ophthalmology
or to '04' if physician's practice is
more than 50% otolaryngology. If
practice is 50/50, choose specialty
with greater allowed charges.
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology-
osteopaths only (deleted 10/91;
changed to '22')
22 = Pathology
23 = Peripheral vascular disease or surgery
(deleted 10/91; changed to '76')
24 = Plastic surgery (revised to mean
plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only)
(deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean
colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean
diagnostic radiology)
31 = Roentgenology, radiology (osteopaths)
(deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table
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10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91
to mean chiropractic)

36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean pediatric medicine)
38 = Geriatrics (revised 10/91 to mean geriatric medicine)
39 = Nephrology
40 = Hand surgery
41 = Optometrist - services related to condition of aphakia (revised 10/91 to mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist (revised 10/91 to mean CRNA, anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised 10/91 to mean podiatry)
49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O. certification (certified orthotist - certified by American Board for Certification in Prosthetics and Orthotics.
52 = Medical supply company with C.P. certification (certified prosthetist - certified by American Board for Certification in Prosthetics and Orthotics).
53 = Medical supply company with C.P.O. certification (certified prosthetist - orthotist - certified by American Board for Certification in Prosthetics and Orthotics).
54 = Medical supply company not included in 51, 52, or 53.
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist - orthotist
58 = Individuals not included in 55,56 or 57
59 = Ambulance service supplier (e.g. private ambulance companies, funeral homes, etc.)
60 = Public health or welfare agencies

(federal, state, and local)
61 = Voluntary health or charitable agencies (e.g. National Cancer Society, National Heart Association, Catholic Charities)
62 = Psychologist--billing independently
63 = Portable X-ray supplier--billing independently (revised 10/91 to mean portable X-ray supplier)
64 = Audiologist (billing independently)

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

65 = Physical therapist (independent practice)
66 = Rheumatology (added 10/91)
67 = Occupational therapist--independent practice
68 = Clinical psychologist
69 = Independent laboratory--billing independently (revised 10/91 to mean independent clinical laboratory -- billing independently)
70 = Clinic or other group practice, except Group Practice Prepayment Plan (GPPP)
71 = Group Practice Prepayment Plan - diagnostic X-ray (do not use after 1/92)
72 = Group Practice Prepayment Plan - diagnostic laboratory (do not use after 1/92)
73 = Group Practice Prepayment Plan - physiotherapy (do not use after 1/92)
74 = Group Practice Prepayment Plan - occupational therapy (do not use after 1/92)
75 = Group Practice Prepayment Plan - other medical care (do not use after 1/92)
76 = Peripheral vascular disease (added 10/91)
77 = Vascular surgery (added 10/91)
78 = Cardiac surgery (added 10/91)
79 = Addiction medicine (added 10/91)
8O = Clinical social worker (1991)
81 = Critical care-intensivists (added 10/91)
82 = Ophthalmology, cataracts specialty (added 10/91; used only until 5/92)
83 = Hematology/oncology (added 10/91)
84 = Preventive medicine (added 10/91)

85 = Maxillofacial surgery (added 10/91)
86 = Neuropsychiatry (added 10/91)
87 = All other (e.g. drug and department stores) (revised 10/91 to mean all other suppliers)
88 = Unknown (revised 10/91 to mean physician assistant)
90 = Medical oncology (added 10/91)
91 = Surgical oncology (added 10/91)
92 = Radiation oncology (added 10/91)
93 = Emergency medicine (added 10/91)
94 = Interventional radiology (added 10/91)
95 = Independent physiological laboratory (added 10/91)
96 = Unknown physician specialty (added 10/91)
99 = Unknown--incl. social worker's psychiatric services (revised 10/91 to mean unknown supplier/provider)

Effective 5/92

00 = Carrier wide
01 = General practice
02 = General surgery
03 = Allergy/immunology

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

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04 = Otolaryngology
05 = Anesthesiology
06 = Cardiology
07 = Dermatology
08 = Family practice
09 = Gynecology (osteopaths only) (discontinued 5/92 use code 16)
10 = Gastroenterology
11 = Internal medicine
12 = Osteopathic manipulative therapy
13 = Neurology
14 = Neurosurgery
15 = Obstetrics (osteopaths only) (discontinued 5/92 use code 16)
16 = Obstetrics/gynecology

17 = Ophthalmology, otology, laryngology, rhinology (osteopaths only) (discontinued 5/92 use codes 18 or 04 depending on percentage of practice)
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology (osteopaths only) (discontinued 5/92 use code 22)
22 = Pathology
23 = Peripheral vascular disease, medical or surgical (osteopaths only) (discontinued 5/92 use code 76)
24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)
32 = Radiation therapy (osteopaths only) (discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = Crna, anesthesia assistant (eff 1/87)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)

47 = Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center (formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)
52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics)
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)
54 = Medical supply company not included in 51, 52, or 53. (Revised 10/93 to mean medical supply company for DMERC)
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist-orthotist
58 = Individuals not included in 55, 56, or 57 (revised 10/93 to mean medical supply company with registered pharmacist)
59 = Ambulance service supplier, e.G., private ambulance companies, funeral homes, etc.
60 = Public health or welfare agencies (federal, state, and local)
61 = Voluntary health or charitable agencies (e.G., National Cancer Society, National Heart Associiation, Catholic Charities)
62 = Psychologist (billing independently)
63 = Portable X-ray supplier

64 = Audiologist (billing independently)
65 = Physical therapist (independently
practicing)
66 = Rheumatology (eff 5/92)
Note: during 93/94 DMERC also used this
to mean medical supply company with
respiratory therapist
67 = Occupational therapist (independently
practicing)
68 = Clinical psychologist
69 = Clinical laboratory (billing
independently)
70 = Multispecialty clinic or group
practice
71 = Diagnostic X-ray (GPPP) (not to
be assigned after 5/92)

1 HCFA_PRVDR_SPCLTY_TB HCFA Provider Specialty Table
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72 = Diagnostic laboratory (GPPP)
(not to be assigned after 5/92)
73 = Physiotherapy (GPPP) (not to be
assigned after 5/92)
74 = Occupational therapy (GPPP)
(not to be assigned after 5/92)
75 = Other medical care (GPPP) (not to
assigned after 5/92)
76 = Peripheral vascular disease
(eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
(eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
department stores) (note: DMERC used
87 to mean department store from 10/93
through 9/94; recoded eff 10/94 to A7;

NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
(note: DMERC used 87 to mean grocery
store from 10/93 - 9/94; recoded eff
10/94 to A8; NCH cross-walked DMERC
reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Independent physiological
laboratory (eff 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility
(eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93)
(DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory
therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use:
eff 10/94, but cross-walked from
code 87 eff 10/93)
A8 = Grocery store (for DMERC use:
eff 10/94, but cross-walked from
code 88 eff 10/93)

1 HCFA_PRVDR_SPCLTY_TB — HCFA Provider Specialty Table

1 HCFA_TYPE_SRVC_TB — HCFA Type of Service Table

1 = Medical care
2 = Surgery

3 = Consultation
4 = Diagnostic radiology
5 = Diagnostic laboratory
6 = Therapeutic radiology
7 = Anesthesia
8 = Assistant at surgery
9 = Other medical items or services
0 = Whole blood only eff 01/96,
whole blood or packed red cells before 01/96
A = Used durable medical equipment (DME)
B = High risk screening mammography
(obsolete 1/1/98)
C = Low risk screening mammography
(obsolete 1/1/98)
D = Ambulance (eff 04/95)
E = Enteral/parenteral nutrients/supplies
(eff 04/95)
F = Ambulatory surgical center (facility
usage for surgical services)
G = Immunosuppressive drugs
H = Hospice services (discontinued 01/95)
I = Purchase of DME (installment basis)
(discontinued 04/95)
J = Diabetic shoes (eff 04/95)
K = Hearing items and services (eff 04/95)
L = ESRD supplies (eff 04/95)
(renal supplier in the home before 04/95)
M = Monthly capitation payment for dialysis
N = Kidney donor
P = Lump sum purchase of DME, prosthetics,
orthotics
Q = Vision items or services
R = Rental of DME
S = Surgical dressings or other medical supplies
(eff 04/95)
T = Psychological therapy (term. 12/31/97)
outpatient mental health limitation (eff. 1/1/98)
U = Occupational therapy
V = Pneumococcal/flu vaccine (eff 01/96),
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
Pneumococcal only before 04/95
W = Physical therapy
Y = Second opinion on elective surgery
(obsoleted 1/97)

Z = Third opinion on elective surgery
(obsoleted 1/97)

1 LINE_ADDTNL_CLM_DCMTN_IND_TB — Line Additional Claim Documentation Indicator Table

0 = No additional documentation
1 = Additional documentation submitted for non-DME EMC claim
2 = CMN/prescription/other documentation submitted which justifies medical necessity
3 = Prior authorization obtained and approved
4 = Prior authorization requested but not approved
5 = CMN/prescription/other documentation submitted but did not justify medical necessity
6 = CMN/prescription/other documentation submitted and approved after prior authorization rejected
7 = Recertification CMN/prescription/other documentation

1 LINE_PLC_SRVC_TB — Line Place Of Service Table

Prior To 1/92

1 = Office
2 = Home
3 = Inpatient hospital
4 = SNF
5 = Outpatient hospital
6 = Independent lab
7 = Other
8 = Independent kidney disease treatment center
9 = Ambulatory
A = Ambulance service
H = Hospice
M = Mental health, rural mental health
N = Nursing home
R = Rural codes

Effective 1/92

11 = Office
12 = Home
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF)
(eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers
(eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally
retarded
55 = Residential substance abuse treatment
facility
56 = Psychiatric residential treatment
center
60 = Mass immunizations center (eff. 9/1/97)
61 = Comprehensive inpatient rehabilitation
facility
62 = Comprehensive outpatient rehabilitation
facility
65 = End stage renal disease treatment facility
71 = State or local public health clinic
72 = Rural health clinic
81 = Independent laboratory

1 LINE_PLC_SRVC_TB Line Place Of Service Table
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99 = Other unlisted facility

1 LINE_PMT_IND_TB Line Payment Indicator Table

1 = Actual charge
2 = Customary charge
3 = Prevailing charge (adjusted, unadjusted gap fill, etc)
4 = Other (ASC fees, radiology and outpatient limits, and non-payment because of denial.
5 = Lab fee schedule
6 = Physician fee schedule - full fee schedule amount
7 = Physician fee schedule - transition
8 = Clinical psychologist fee schedule
9 = DME and prosthetics/orthotics fee schedules (eff. 4/97)

1 LINE_PRCSG_IND_TB — Line Processing Indicator Table

A = Allowed
B = Benefits exhausted
C = Noncovered care
D = Denied (existed prior to 1991; from BMAD)
I = Invalid data
L = CLIA (eff 9/92)
M = Multiple submittal--duplicate line item
N = Medically unnecessary
O = Other
P = Physician ownership denial (eff 3/92)
Q = MSP cost avoided (contractor #88888) - voluntary agreement (eff. 1/98)
R = Reprocessed--adjustments based on subsequent reprocessing of claim
S = Secondary payer
T = MSP cost avoided - IEQ contractor (eff. 7/76)
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96)
V = MSP cost avoided - litigation settlement (eff. 7/96)

X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
match project
Z = Bundled test, no payment
(eff. 1/1/98)

1 LINE_PRVDR_PRTCPTG_IND_TB — Line Provider Participating Indicator Table

1 = Participating
2 = All or some covered and allowed
expenses applied to deductible Participating
3 = Assignment accepted/non-participating
4 = Assignment not accepted/non-participating
5 = Assignment accepted but all or some
covered and allowed expenses applied
to deductible Non-participating.
6 = Assignment not accepted and all covered
and allowed expenses applied to deductible
non-participating.
7 = Participating provider not accepting
assignment.

1 NCH_CLM_TYPE_TB — NCH Claim Type Table

10 = HHA claim
20 = Non swing bed SNF claim
30 = Swing bed SNF claim
40 = Outpatient claim
41 = Outpatient 'Full-Encounter' claim
(available in NMUD)
42 = Outpatient 'Abbreviated-Encounter' claim
(available in NMUD)
50 = Hospice claim
60 = Inpatient claim
61 = Inpatient 'Full-Encounter' claim
62 = Inpatient 'Abbreviated-Encounter claim
(available in NMUD)
71 = RIC O local carrier non-DMEPOS claim
72 = RIC O local carrier DMEPOS claim
73 = Physician 'Full-Encounter' claim

(available in NMUD)
81 = RIC M DMERC non-DMEPOS claim
82 = RIC M DMERC DMEPOS claim

1 NCH_EDIT_TB NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
A000 = (C) REIMB > $100,000 OR UNITS > 150
A002 = (C) CLAIM IDENTIFIER (CAN)
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
A004 = (C) PATIENT SURNAME BLANK
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
A006 = (C) DATE OF BIRTH IS NOT NUMERIC
A007 = (C) INVALID GENDER (0, 1, 2)
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
A1X1 = (C) PERCENT ALLOWED INDICATOR
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
A1X3 = (C) DT>96365,DIAG=V725
A1X4 = (C) INVALID DIAGNOSTIC CODES
C050 = (U) HOSPICE - SPELL VALUE INVALID
D102 = (C) DME DATE OF BIRTH INVALID
D2X2 = (C) DME SCREEN SAVINGS INVALID
D2X3 = (C) DME SCREEN RESULT INVALID
D2X4 = (C) DME DECISION IND INVALID
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
D3X1 = (C) DME NATIONAL DRUG CODE INVALID
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
D4X2 = (C) DME OUT OF DMERC SERVICE AREA
D4X3 = (C) DME STATE CODE INVALID
D5X1 = (C) TOS INVALID FOR DME HCPCS
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
D5X3 = (C) DME INVALID USE OF MS MODIFIER
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
D6X1 = (C) DME SUPPLIER NUMBER MISSING
D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1

Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER

1 NCH_EDIT_TB NCH EDIT TABLE
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0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME HCPCS
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT

0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
0705 = (C) INVALID CONT FOR PCOE DEMO
0901 = (C) INVALID DISP CODE OF 02
0902 = (C) INVALID DISP CODE OF SPACES
0903 = (C) INVALID DISP CODE
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
1301 = (C) LINE COUNT NOT NUMERIC OR > 13
1302 = (C) RECORD LENGTH INVALID
1401 = (C) INVALID MEDICARE STATUS CODE
1501 = (C) ADMIT DATE/ENTRY CODE INVALID
1502 = (C) ADMIT DATE > STAY FROM DATE
1503 = (C) ADMIT DATE INVALID WITH THRU DATE
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
1505 = (C) HCPCS W SERVICE DATES > 09-30-94
1601 = (C) INVESTIGATION IND INVALID
1701 = (C) SPLIT IND INVALID
1801 = (C) PAY-DENY CODE INVALID
1802 = (C) HEADER AMT AND NOT DENIED CLAIM
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
1901 = (C) AB CROSSOVER IND INVALID
2001 = (C) HOSPICE OVERRIDE INVALID
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
2202 = (C) STAY-FROM DATE > THRU-DATE
2203 = (C) THRU DATE INVALID
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
2207 = (C) MAMMOGRAPHY BEFORE 1991
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
2302 = (C) COVERED DAYS INVALID OR INCONSIST
2303 = (C) COST REPORT DAYS > ACCOMIDATION
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
2305 = (C) UTIL DAYS = INCONSISTENCIES
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09

1 NCH_EDIT_TB NCH EDIT TABLE
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2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
2401 = (C) NON-UTIL DAYS INVALID
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL

2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
2504 = (C) COINSURANCE AMOUNT EXCESSIVE
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28XO = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17

35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
4002 = (C) BLOOD FURNISHED/REPLACED INVALID

1 NCH_EDIT_TB NCH EDIT TABLE

4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
4201 = (C) BLOOD PINTS UNREPLACED INVALID
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
4203 = (C) INVALID CPO PROVIDER NUMBER
4301 = (C) BLOOD DEDUCTABLE INVALID
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
4304 = (C) BLOOD DEDUCT > 3 - REPLACED
4501 = (C) PRIMARY DIAGNOSIS INVALID
46XA = (C) MSP VET AND VET AT MEDICARE
46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
46XG = (C) VALU CODE 20 INVALID
46XN = (C) VALUE CODE 37,38,39 INVALID
46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
46XR = (C) BLD FIELDS VS REV CDE 380,381,382
46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
46X1 = (C) VALUE AMOUNT INVALID
46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES

4601 = (C) CABG/PCOE, MSP CODE PRESENT
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
4901 = (C) PCOE/CABG,DEN CD NOT D
4902 = (C) PCOE/CABG BUT DME
50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
50X2 = (C) REV CD=054X,MOD NOT = QM,QN
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
51XD = (C) HCPCS REQUIRES UNITS > ZERO
51XE = (C) HCPCS REQUIRES REVENUE CODE 636
51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS
51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
51XM = (C) 21X,RC>9041/<9045,RC<>4/234
51XN = (C) 21X,RC>9032/<9042,RC<>4/234
51XP = (C) HHA RC DATE OF SRVC MISSING
51XQ = (C) NO RC 0636 OR DTE INVALID
51XR = (C) DEMO ID=01,RIC NOT=2
51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
51X0 = (C) REV CENTER CODE INVALID
51X1 = (C) REV CODE CHECK

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51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
51X3 = (C) UNITS MUST BE > 0
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
51X9 = (C) HCPCS/REV CODE/BILL TYPE
5100 = (U) TRANSITION SPELL / SNF
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
5169 = (U) PROVIDER NE TO WORK PROVIDER

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5177 = (U) PROVIDER NE TO WORK PROVIDER
5178 = (U) HOSPICE BILL THRU < DOLBA
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
5200 = (E) ENTITLEMENT EFFECTIVE DATE
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
5202 = (U) HOSPICE TRAILER ERROR
5203 = (E) ENTITLEMENT HOSPICE PERIODS
5203 = (U) HOSPICE START DATE ERROR
5204 = (U) HOSPICE DATE DIFFERENCE NE 90
5205 = (U) HOSPICE DATE DISCREPANCY
5206 = (U) HOSPICE DATE DISCREPANCY
5207 = (U) HOSPICE THRU > TERM DATE 2ND
5208 = (U) HOSPICE PERIOD NUMBER BLANK
5209 = (U) HOSPICE DATE DISCREPANCY
5210 = (E) ENTITLEMENT FRM/TRU/END DATES
5211 = (E) ENTITLEMENT DATE DEATH/THRU
5212 = (E) ENTITLEMENT DATE DEATH/THRU
5213 = (E) ENTITLEMENT DATE DEATH MBR
5220 = (E) ENTITLEMENT FROM/EFF DATES
5225 = (E) ENT INP PPS SPAN 70 DATES
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
5233 = (E) ENTITLEMENT HMO PERIODS
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
5236 = (E) ENTITLEMENT HMO HOSP + CC07
5237 = (E) ENTITLEMENT HOSP OVERLAP
5238 = (U) HOSPICE CLAIM OVERLAP > 90
5239 = (U) HOSPICE CLAIM OVERLAP > 60
524Z = (E) HOSP OVERLAP NO OVD NO DEMO
5240 = (U) HOSPICE DAYS STAY+USED > 90
5241 = (U) HOSPICE DAYS STAY+USED > 60
5242 = (C) INVALID CARRIER FOR RRB
5243 = (C) HMO=90091,INVALID SERVICE DTE
5244 = (E) DEMO CABG/PCOE MISSING ENTL
5245 = (C) INVALID CARRIER FOR NON RRB
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
5250 = (U) HOSPICE DOEBA/DOLBA
5255 = (U) HOSPICE DAYS USED
5256 = (U) HOSPICE DAYS USED > 999
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
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5299 = (U) HOSPICE PERIOD NUMBER ERROR

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5320 = (U) BILL > DOEBA AND IND-1 = 2
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
5355 = (U) HOSPICE DAYS USED SECONDARY
5378 = (C) SERVICE DATE < AGE 50
5399 = (U) HOSPICE PERIOD NUM MATCH
5410 = (U) INPAT DEDUCTABLE
5425 = (U) PART B DEDUCTABLE CHECK
5430 = (U) PART B DEDUCTABLE CHECK
5450 = (U) PART B COMPARE MED EXPENSE
5460 = (U) PART B COMPARE MED EXPENSE
5499 = (U) MED EXPENSE TRAILER MISSING
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
5510 = (U) COIN DAYS/SNF COIN DAYS
5515 = (U) FULL DAYS/COIN DAYS
5516 = (U) SNF FULL DAYS/SNF COIN DAYS
5520 = (U) LIFE RESERVE DAYS
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
5540 = (U) HH VISITS NE AFT PT B TRLR
5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I

59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID

1 NCH_EDIT_TB NCH EDIT TABLE

6000 = (U) ADJUSTMENT BILL SPELL DATA
6020 = (U) CURRENT SPELL DOEBA < 1990
6030 = (U) ADJUSTMENT BILL SPELL DATA
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
61X1 = (C) PAY PROCESS IND INVALID
61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED

6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.

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69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
69X3 = (C) PROC CODE MOD = LL / TYPE = R
69X6 = (C) PROC CODE MOD/NOT CAPPED
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
6902 = (C) KRON IND AND NO-PAY CODE B OR N

6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
6904 = (C) KRON IND AND TRANS CODE IS 4
6910 = (C) REV CODES ON HOME HEALTH
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
6913 = (C) REV CODE INVAL FOR OXYGEN
6914 = (C) REV CODE INVAL FOR DME
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
6918 = (C) HCPCS INVALID ON DATE RANGES
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
6929 = (U) ADJUSTMENT BILL LIFE RESERVE
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
7000 = (U) INVALID DOEBA/DOLBA
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
71X1 = (C) SUBMITTED CHARGES INVALID
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
72X1 = (C) ALLOWED CHGS INVALID
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
72X3 = (C) DENIED LINE/ALLOWED CHARGES
73X1 = (C) SS NUMBER INVALID
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
77X1 = (C) PLACE OF SERVICE INVALID
77X2 = (C) PHYS THERAPY/PLACE
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
77X6 = (C) TOS=F, PL OF SER NOT = 24
7701 = (C) INCORRECT MODIFIER
7777 = (D) POSS DUPE, PART B DOC-ID
78XA = (C) MAMMOGRAPHY BEFORE 1991
78X1 = (C) THRU DATE INVALID
78X3 = (C) FROM DATE GREATER THAN THRU DATE
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%

78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
8028 = (E) NO ENTITLEMENT
8029 = (U) HH BEFORE PERIOD NOT PRESENT
8030 = (U) HH BILL VISITS > PT A REMAINING
8031 = (U) HH PT A REMAINING > 0

1	NCH_EDIT_TB	NCH EDIT TABLE
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8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
8050 = (U) HH QUALIFYING INDICATOR = 1
8051 = (U) HH # VISITS NE AFT PT B APPLIED
8052 = (U) HH # VISITS NE AFT TRAILER
8053 = (U) HH BENEFIT PERIOD NOT PRESENT
8054 = (U) HH DOEBA/DOLBA NOT > 0
8060 = (U) HH QUALIFYING INDICATOR NE 1
8061 = (U) HH DATE NE DOLBA IN AFT TRLR
8062 = (U) HH NE PT-A VISITS REMAINING
81X1 = (C) NUM OF SERVICES INVALID
83X1 = (C) DIAGNOSIS INVALID
8301 = (C) HCPCS/GENDER DIAGNOSIS
8302 = (C) HCPCS G0101 V-CODE/SEX CODE
8304 = (C) BILL TYPE INVALID FOR G0123/4
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
84X2 = (C) INVALID DME START DATE
84X3 = (C) INVALID DME START DATE W/HCPCS
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
84X5 = (C) HCPCS CODE WITH INV DIAG CODE
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
9000 = (U) DOEBA/DOLBA CALC
9005 = (U) FULL/COINS HOSP DAYS CALC
9010 = (U) FULL/COINS SNF DAYS CALC
9015 = (U) LIFE RESERVE DAYS CALC
9020 = (U) LIFE PSYCH DAYS CALC
9030 = (U) INPAT DEDUCTABLE CALC
9040 = (U) DATA INDICATOR 1 SET
9050 = (U) DATA INDICATOR 2 SET
91X1 = (C) PATIENT REIMB/PAY-DENY CODE
92X1 = (C) PATIENT REIMB INVALID
92X2 = (C) PROVIDER REIMB INVALID
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB

92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
92X7 = (C) REIMB/PAY-DENY INCONSISTANT
9201 = (C) UPIN REF NAME OR INITIAL MISSING
9202 = (C) UPIN REF FIRST 3 CHAR INVALID
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
93X1 = (C) CASH DEDUCTABLE INVALID
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
93X4 = (C) FROM DATE/CASH DEDUCTIBLE
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
9300 = (C) UPIN OTHER, NOT PRESENT
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
94A1 = (C) NON-COVERED FROM DATE INVALID
94A2 = (C) NON-COVERED FROM > THRU DATE
94A3 = (C) NON-COVERED THRU DATE INVALID
94A4 = (C) NON-COVERED THRU DATE > ADMIT
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
94C1 = (C) PR-PSYCH DAYS INVALID
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
94F1 = (C) REIMBURSEMENT AMOUNT INVALID
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
94G1 = (C) NO-PAY CODE INVALID

1 NCH_EDIT_TB NCH EDIT TABLE
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94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
94G4 = (C) NO PAY CODE = R & REIMB PRESENT
94X1 = (C) BLOOD LIMIT INVALID
94X2 = (C) TYPE/BLOOD DEDUCTIBLE
94X3 = (C) TYPE/DATE/LIMIT AMOUNT
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
9401 = (C) BLOOD DEDUCTIBLE AMT > 3
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
9404 = (C) INVALID GENDER CODE ON PRO-PAY
9407 = (C) INVALID DRG NUMBER
9408 = (C) INVALID DRG NUMBER (GLOBAL)
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE,INVALID DRG

95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER

1 NCH_NEAR_LINE_RIC_TB — NCH Near-Line Record Identification Code Table

O = Part B physician/supplier claim
record (processed by local carriers;

can include DMEPOS services)
V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)
W = Part B institutional claim record (outpatient (OP), HHA)
U = Both Part A and B institutional home health agency (HHA) claim records -- due to HHPPS and HHA A/B split. (effective 10/00)
M = Part B DMEPOS claim record (processed by DME Regional Carrier) (effective 10/93)

1 NCH_PATCH_TB NCH Patch Table

01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.
02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.
03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' ocnversion, patch applied to Nearline claims where garbage or nonnumeric values.

04 = Incorrect bene residence SSA standard county
code '999' changed (all claim types) --
applied during the Nearline 'G' conversion and
ongoing through 4/21/94, calling EQSTZIP
routine to claims with NCH weekly process
date prior to 4/22/94. Prior to Version 'H'
patch indicator stored in redefined Claim
Edit Group, 3rd occurrence, position 4.
05 = Wrong century bene birth date corrected (all
claim types) -- applied during Nearline 'H'
conversion to all history where century
greater than 1700 and less than 1850; if
century less than 1700, zeroes moved.
06 = Inconsistent CWF bene medicare status code
made consistent with age (all claim types) --
applied during Nearline 'H' conversion to all
history and patched ongoing. Bene age is
calculated to determine the correct value;
if greater than 64, 1st position MSC ='1';
if less than 65, 1st position MSC = '2'.
07 = Missing CWF bene mediare status code derived
(all claim types) -- applied during Nearline
'H' conversion to all history and patched
ongoing, except claims with unknown DOB and/
or Claim From Date='0' (left blank). Bene
age is calculated to determine missing value;
if greater than 64, MSC='10'; if less than
65, MSC = '20'.
08 = Invalid NCH primary payer code set to blanks
(Instnl) -- applied during Version 'H' con-
version to claims with NCH weekly process
date 10/1/93-10/30/95, where MSP values =

1 NCH_PATCH_TB NCH Patch Table
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invalid '0', '1', '2', '3' or '4' (caused
by erroneous logic in HCFA program code,
which was corrected on 11/1/95).
09 = Zero CWF claim accretion date replaced with
NCH weekly process date (all claim types)
-- applied during Version 'H' conversion to
Instnl and DMERC claims; applied during
Version 'G' conversion to non-institutional
(non-DMERC) claims. Prior to Version 'H',

patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.

10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/ SNF (the problem was only found with OP/HHA/ Hospice claims). The problem was corrected 6/25/99.

11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch was done for records with NCH Daily Process Date 1/4/99 - 5/14/99.

12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.

13 = Inconsistent Claim MCO Paid Switch made consistent with criteria used to identify an inpatient encounter claim -- if MCO paid switch equal to blank or '0' and ALL conditions are met to indicate an inpatient encounter claim (bene enrolled in a risk MCO during the service period), change the switch to a '1'. The patch was applied during the Version 'I' conversion, for claims back to 7/1/97 service thru date.

1 NCH_STATE_SGMT_TB — NCH State Segment Table

01 = Alabama
02 = Alaska
03 = Arizona
04 = Arkansas
05 = California
06 = Colorado

07 = Connecticut
08 = Delaware
09 = District of Columbia
10 = Florida
11 = Georgia
12 = Hawaii
13 = Idaho
14 = Illinois
15 = Indiana
16 = Iowa
17 = Kansas
18 = Kentucky
19 = Louisiana
20 = Maine
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennesee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington

51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada
57 = Central America & West Indies

1 NCH_STATE_SGMT_TB NCH State Segment Table
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58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = US Possessions
97 = Saipan - MP
98 = Guam
99 = American Samoa